USAID SUM II YEAR-2 MONITORING & EVALUATION REPORT

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Contents

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APMG	AIDS Projects Management Group
APBD	Anggaran Pendapatan Belanja Daerah **(**Regional Budget)
ARV	Antiretroviral
BAPPEDA	Badan Perencana Pembangunan Daerah (Regional Office for Planning and Development)
BI	Burnet Institute
CSO	Civil society organization
CST	Care, support, treatment
DAC	District AIDS Commissions
DHO	District Health Office
DINKES	Dinas Kesehatan (Provincial Health Office)
DINPAR	Dinas Pariwisata (Regional Tourism Office)
DINSOS	Dinas Sosial (Regional Social Welfare Office)
DQA	Data quality audit
DPRD	Dewan Perwakilan Rakyat Daerah (Regional People's Representative Council)
ERA	Expanded readiness assessment
FHI	Family Health International
FSW	Female sex worker
GF	Global Fund
HIV	Human Immunodeficiency Virus
HRM	High risk men
HSS	Health systems strengthening
IBBS	Integrated Biological and Behavior Survey
IEC	Information, Education and Communication
IDUs	Injecting drug users
KDS	Kelompok Dukungan Sebaya (peer support groups)
KPAD	City/District AIDS Commissions
KPAP	Provincial AIDS Commission, Indonesia
MARP	Most-at-risk population
MDG	Millennium Development Goals
MMT	Methadone maintenance therapy
MOU	Memorandum of understanding
MSM	Men who have sex with men
NSP	Needle sharing program
PAC	Provincial AIDS commission
PE	Peer educators
PHO	Provincial health office
PKBI	Persatuan Keluarga Berencana Indonesia (Indonesia Family Planning Association)

PKM	Pusat Kesehatan Masyarakat (Community Health Center)
POKJA LOKASI	Kelompok kerja lokalisasi (brothel working groups)
QAQI	Quality assurance quality improvement
RSUD	Rumah sakit umum daerah
RTI	Research Triangle Institute, International
STI	Sexually transmitted infection
SUM Program	USAID Scaling-Up for Most-at-Risk Populations Program (a joint program of SUM I and SUM II)
SUM I	USAID Scaling Up for Most-at-Risk Populations: Technical Assistance
SUM II	USAID Scaling Up for Most-at-Risk Populations: Organizational Performance
TG	Transgender
TRG	Training Resources Group
USAID	U.S. Agency for International Development
VCT	Voluntary, Counseling and Testing
YBS	Yayasan Bentan Serumpun (CSO in Riau Islands)
YGB	Yayasan Gaya Batam (CSO in Riau Islands)
YKIE	Yayasan Komunikasi Informasi dan Edukasi Batam (CSO in Riau Islands)

EXECUTIVE SUMMARY

Indonesia's HIV and AIDS epidemic is concentrated in key affected populations resulting from a mix of two modes of transmissions, sexual transmission and drug injecting. With the exception of Papua, the epidemic is a concentrated in most-at-risk populations – IDUs (36%), TG (43%), FSW (7%), and MSM (8%). The epidemic in Papua and West Papua provinces is generalized and driven largely by commercial sex. The cumulative number of reported HIV infections in Indonesia has risen sharply from 7,195 in 2006 to 76,879 by 2011.

The USAID SUM Program is specifically designed to focus on scaling-up integrated interventions serving most-at-risk populations (MARPs) in six provinces of Jakarta, East Java, Central Java, West Java, North Sumatra and Riau Islands, as well as the general population in two provinces, Papua and West Papua. The most-at-risk populations (MARPs) include female sex workers (FSWs), men who have sex with men (MSM), injecting drug users (IDUs), Transgenders (*Waria*), and high-risk men (HRM or the clients of sex workers) in selected locations. The SUM Program consists of the SUM I and SUM II projects – SUM I is being implemented by FHI, and provides targeted assistance in technical capacity required to scale-up effective, integrated interventions; and SUM II is being implemented by the Training Resources Group (TRG), along with partners RTI International, Burnet Institute and AIDS Projects Management Group (APMG), and provides targeted assistance in organizational performance required to scale-up effective, integrated interventions.

SUM II at the beginning of Year 2, believing that traditional classroom-based training has not resulted in improved CSO organizational capacity, launched an intensive workplace program of on-the-job training and coaching, in partnership with local TA providers in organizational performance. Now, at the completion of Year 2, and based on organizational performance, CSOs have been categorized as principal, developing or suspended. Five CSOs are designated as *principle* CSOs, twenty-two CSOs are designated as *developing* CSOS (including three CSOs in North Sumatra and five CSOs in Riau Islands), and two CSOs are designated as *suspended* CSOs – one each in DKI Jakarta and East Java.

Principle CSOs receive expanded scopes of work and intensive coaching from SUM II TA partners to enable them to become *local capacity building coaches* to developing CSOs (financial, management and program skills and systems). In Year 2, three local TA organizations supported the CSO capacity building program: Penabulu, Satunama, and Circle Indonesia.

Year-2 Targets: The target for the number of districts in which ERAs, OP/TC and health-sector assessments have been undertaken has been achieved for year 2 and for the life of the project. The assessments will not continue. Twenty-one CSOs have approved grants, which is short of the target of 29. Four CSOs in Riau Islands and three in North Sumatra will be issued grants next quarter raising the number to 28. District Offices and AIDS Commissions are supporting SUM partner CSOs. Nine CSOs leveraged funds from other sources in Year 2 (see section 3.4), which greatly exceeds expectations and target.

The increase in the number of MARP individuals reached during the fourth quarter of Year 2 reflects the contribution by Papua CSOs and the total number of individuals reached in Year 2 exceeds the target. However, HIV counseling and testing remains disappointing at intervention sites. Only 40% of the target for year 2 was achieved.

STI services exceeded the Year-2 target and it is much the same scenario with accessing HIV services at targeted intervention sites. The achievement was almost double the target. The number of HIV-positive adults and children receiving a minimum of one clinical service exceeded the year-2 target by 27%. Fifty percent of the services delivered during the year were delivered in the last quarter. The dramatic surges in services recorded during the last quarter are predominately attributed to delayed data entry by CSOs.

INTRODUCTION

Indonesia, with its population of 237.5 million in 2010, has an estimated HIV prevalence of 0.27% among the 15-49 years age group. The country's HIV and AIDS epidemic is concentrated in key affected population resulting from a mix of two modes of transmissions, sexual transmission and drug injecting.[1] The epidemic has not changed from a concentrated epidemic since the 2010 UNGASS report, with high HIV prevalence in some most-at-risk populations, namely IDUs (36%), TG (43%), FSW (7%), and MSM (8%). In the last 4 years, there has been a noticeable shift in the predominant mode of infection among reported AIDS cases (cumulative) from 2,873 (2007) to 29,879 (2011). Unsafe injecting is no longer the dominant mode of infection.

While in 2007, 49.8% of new reported AIDS were drug related and 41.8% were the result of heterosexual transmission, by 2011 that situation had changed with only 18.7% of the total new reported AIDS cases associated with injecting drug use and 71% were the result of heterosexual infection.[2] The HIV epidemic in Papua and West Papua provinces is generalized, and different from the rest of the country, and driven largely by commercial sex. The cumulative number of reported HIV infections in Indonesia has risen sharply from 7,195 in 2006 to 76,879 by 2011.[3] According to the 2009 national estimates of HIV infection, about 186,257 people were infected with HIV and 6.4 million people were at risk.[4]

In May 2010, USAID Indonesia launched the *Scaling Up for Most-At-Risk Populations (SUM)* Program 2010–2015. The SUM program is contributing to the Government of Indonesia's goal to slow the number of new HIV infections by supporting four core strategies of the Indonesia National Action Plan:

[1] *Republic of Indonesia Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting Period 2010-2011.* Indonesia National AIDS Commission. 2012. 179 pages
[2] MoH, *Year-end Report on Situation of HIV and AIDS in Indonesia*, 2007 and 2011
[3] MoH, *Year-end Report on Situation of HIV and AIDS in Indonesia*, 2006 and 2011.
[4] *MoH, Estimation of at-risk Adult Population, 2009*

- Strengthening national leadership
- Strengthening the National AIDS Commission (NAC)
- Scaling up prevention, care, support and treatment with a focus on most-at-risk populations (MARP)
- Strengthening the community response for mobilization and participation.

The SUM program is specifically designed to focus on scaling-up integrated interventions serving selected most-at-risk populations (MARP) in eight (8) provinces of Jakarta, East Java, Central Java, West Java, North Sumatra and Riau Islands; and the general population in two provinces, Papua and West Papua. The most-at-risk populations (MARPs) include: sex workers (female, male, and transgender or *Waria*), clients of sex workers (HRM), men who have sex with men (MSM), and intravenous drug users (IDU).

Fundamental Objectives of the SUM I and SUM II Projects

SUM I

1. Provide the targeted assistance in key technical areas required to scale-up effective, integrated HIV interventions that lead to substantial and measurable behavior change among MARPs.
2. Provide targeted assistance to government agencies and civil society organizations working on strategic information efforts related to the HIV response for MARPs, including integrated bio-behavioral surveillance (IBBS) and monitoring and evaluation.

SUM II

1. Provide the targeted assistance in organizational performance required to scale-up effective, integrated HIV interventions that lead to substantial and measurable behavior change among MARPs.
2. Provide and monitor small grants to qualified civil society organizations to support the scale up of integrated interventions in "hotspots," where there is a high concentration of one or more most-at-risk population and high-risk behavior is prevalent.

Built into the SUM program were the lessons learned from the 1995–2000 HAPP, the 2000–2005 ASA I and 2005–2008 ASA II programs, and the 2006-2009 HPI project and access to best practices from international experience.

The USAID SUM Program consists of the SUM I and SUM II projects: SUM I is being implemented by FHI, and SUM II is being implemented by the Training Resources Group (TRG), along with partners RTI International, Burnet Institute and AIDS Projects Management Group (APMG). The fundamental objectives of the respective projects are as shown in the adjacent text box.

1. DKI Jakarta

SUM I and SUM II initiated activities in DKI Jakarta in Year 1 with *Expanded Readiness Assessments* in eight communities, *Organizational Performance and Technical Capacity (OP/TC) Baseline Assessments,* CSO partner selection, and provision of small grants to 7 CSOs.
DKI Jakarta has the highest cumulative number of HIV and AIDS cases in Indonesia at 20,126 and 5,118, respectively (MOH 2012). Its AIDS prevalence per 100,000 is 4 times more than the national average. In 2009, the Ministry of Health estimated there were 99,146 MSMs, 36,011 FSWs, 27,852 IDUs, and 2,008 transgenders in DKI Jakarta, and 7,992 MSM, 2,646 FSWs, 15,324

IDUs and 682 transgenders were living with HIV/AIDS. Prevalence rates of HIV vary considerably among MARPs in DKI Jakarta; and the IBBS 2011 revealed that HIV prevalence among these most-at-risk populations also varied greatly between districts of DKI Jakarta.

2. East Java

SUM I and SUM II initiated activities in East Java Province in Year 1 with *Expanded Readiness Assessments* in seven communities, *Organizational Performance and Technical Capacity (OP/TC) Baseline Assessments,* CSO partner selection, and provision of small grants to 7 CSOs. East Java has the second highest cumulative number of HIV and AIDS cases in Indonesia at 10,781 and 4,663 respectively. The prevalence of AIDS cases per 100,000 is 12.27 (MOH 2012). In 2009, the Ministry of Health reported an estimated 79,533 MSM, 19,090 FSWs, 22,308 IDUs, and 4,170 transgenders in East Java, and estimated 4,455 MSM, 1,038 FSWs, 12,492 IDUs, and 1,045 transgenders living with HIV/AIDS, respectively. The 2011 IBBS HIV shows prevalence of 48.8% among IDUs in Surabaya and 36.4% in Malang; 24% among transgender in Surabaya and 17% in Malang; 9.6% among MSM in Surabaya and 2.5% in Malang; 10.4% among direct female sex worker in Surabaya; and 2% among indirect sex worker in Surabaya.

3. Papua

SUM I and SUM II initiated activities in Papua in Year 2 with *Expanded Readiness Assessments* in seven communities, *Organizational Performance and Technical Capacity (OP/TC) Baseline Assessments,* CSO partner selection, and provision of small grants to 6 CSOs.

While most provinces face a concentrated epidemic amongst key affected populations, by 2006 evidence showed that across the two provinces of Papua and West Papua a low-level general population epidemic was underway, with HIV prevalence of 2.4% among the general population. It is fueled almost completely by unsafe sexual intercourse (MoH, IBBS Tanah Papua, 2006).

A sharp increase in HIV among Papuans has been observed in recent years with the highest per capita prevalence of HIV/AIDS in Indonesia. By December 2011, its AIDS case prevalence per 100,000 people was 12.6 times more than the national average (MOH, 2012). In Papua province, unprotected sex is the main mode of transmission. Papua also has a high HIV prevalence among female sex workers (FSWs). In 2000, prevalence rates of HIV varied considerably among females by sex work venues. In 2006, the National AIDS Commission reported HIV prevalence of 14%-16% among sex workers in Nabire, Merauke, and Sorong. Most recently, the IBBS 2011 revealed that HIV prevalence was 25% among direct FSWs in Jayawijaya District and 16% in Jayapura City, and 3.2% among indirect FSWs in Jayapura City. High-risk men in Papua also have a higher rate of HIV prevalence in comparison to other parts in Indonesia, with HIV infection rates of 2% among motorcycle taxi drivers and 3% among dock workers (MOH, 2012).

Sexual violence has been reported as a possible explanation of Papua's growing epidemic as has circumcision status. One in eight (12%) women reported that they have been forced to have sex by their domestic partners. Likewise, HIV prevalence among men with non-regular partners was found to be almost six times higher in uncircumcised men, compared with their circumcised counterparts in 2007 (5.6% versus 1%).

4. Riau Islands

SUM I and SUM II initiated activities in Riau Islands in Year 2 with *Expanded Readiness Assessments* in ten communities. Five CSO partners have been selected and SUM II is in the process of providing them with small grants.

In 2009, the MOH reported 106,763 clients of FSWs, 11,073 FSWs, 10,261 MSM, 1,226 IDUs, and 990 transgenders with 1,300 clients of FSWs, 1,101 FSWs, 206 MSM, 556 IDUs, and 178 transgenders living with HIV/AIDS (MOH, 2010).These figures show the presence of HIV/AIDS in the province, particularly in high risk men. By December 2011, Indonesian health officials reported the prevalence of AIDS cases per 100,000 people at 24.06. Furthermore, through March 2012 it was reported that there were 2,380 HIV cases and 409 AIDS cases. Almost 50% of the reported HIV-positive cases in Riau Islands can be attributed to heterosexual transmission. In addition, 56% of the reported HIV-positive cases in Riau Islands were in the 25-29 years age group. Batam city has the highest number of HIV/AIDS cases with 410 HIV and 158 AIDS cases. The IBBS 2011 reported HIV prevalence of 10% and 7% among direct and indirect female sex workers in Batam City, and HIV prevalence among high-risk men (seafarers) at 0.8% (MOH, 2012).

5. North Sumatra

SUM I and SUM II initiated activities in North Sumatra in Year 2 with *Expanded Readiness Assessments* in ten communities. Three CSO partners and one forum have been selected and SUM II is in the process of providing them with small grants.

In 2009, there were 1,226 IDUs, 4,547 direct FSWs, 6,526 indirect FSWs, 990 transgenders, 10,261 MSM, and 509 cumulative AIDS cases and 94 deaths. Moreover, thru December 2011 the prevalence of AIDS cases per 100,000 people was 3.97. By mid-2012 the numbers of HIV and AIDS cases had reached 5,405 and 515, respectively. The IBBS 2011 reported HIV prevalence among IDUs in Medan at 39.2%, 3.6% among direct female sex worker in Deli Serdang, 3.2% among indirect female sex workers, and 1.3% among high-risk men in Medan, and in Deli Serdang, 0.3%.

6. SUM Years 1 and 2

SUM Year 1 implementation activities are highlighted or summarized in the different sections of this report because they lay the foundation for Year 2. In parallel to initiating activities with 15 CSOs serving four most-at-risk populations in DKI Jakarta and East Java, the SUM Program in Year 1 adapted and applied three program development tools to the Indonesia context:

- *Expanded Readiness Assessment:* This assessment is a semi-structured questionnaire applied with a highly participatory, focus group approach, enabling multiple stakeholders from MARPs, district and provincial government, service providers and CSOs to collectively measure their community's level of readiness in the HIV response (see 2.1).

- *Organizational Performance and Technical Capacity (OP/TC) Assessment:* This tool provides as a baseline for SUM II and the CSO to monitor improvements in the organization's capacity over time. It was applied in DKI Jakarta, East Java, and Papua, and then discontinued because it was too labor intensive for SUM's limited staff resources and slowed the grant disbursement process. Moreover, SUM II's approach to CSO capacity building at the start of Year 2 was to shift from the traditional classroom-based training of previous programs to a more intensive program of workplace-based, on-the-job training, coaching, and systems development. This approach made the OP/TC assessment process redundant (see 2.1).

- *Resource Estimation Tool for Advocacy (RETA):* This tool estimates the level of finances needed to scale up HIV programming over a 5-year period, based on population size estimates, local costs of HIV prevention, care, treatment and support programs, and service coverage targets. It was originally developed as a HIV programming tool for men who have sex with men, and in Year 1 SUM II expanded the tool so it can be applied to programming for female sex workers, transgender people and injecting drug users. Application of this tool in Year 2 in East Java and Jakarta has already resulted in leveraged funds from local governments that have far exceeded expectations (see 3.4).

Completion of two implementation guides was also a Year 1 deliverable under USAID SUM's task order – one for an integrated sex work intervention and a second for an "integrated MSM intervention. During development of the two guides, it was determined that the guide for integrated MSM intervention needed to in fact be two separate guides – one guide for men who have sex with men (MSM) and a second guide for transgender (TG) persons, since intervention approaches are different for these two most-at-risk populations. It was also determined that an additional guide was needed for injecting drug users (IDUs). As such four implementation guides were produced in Year 1. In each of the four Implementation Guides, SUM II prepared Section 1, Organizational Performance (OP), and SUM 1 prepared Section 2, Technical Capacity (TC).

Also in Year 1, SUM II produced eight how-to modules that are currently being used by SUM II-funded local TA organizations in SUM II's intensive CSO workplace training, coaching and systems development program (see 3.1). They include:

Stand-Alone How-to Modules

- *Module 1 – CSO Start-Up (April 2011. 29 pages)*
- *Module 2 – CSO Strategic Planning (April 2011. 29 pages)*
- *Module 3 – CSO Human Resources Management (April 2011. 50 pages)*
- *Module 4 – CSO Program Planning (May 2011. 83 pages)*
- *Module 5 – CSO Policies and Procedures (June 2011. 16 pages)*
- *Module 6 – Mobilizing for MARPs (June 2011. 32 pages)*
- *Module 7 –Strategies for Effective MARPs-based Advocacy (June 2011. 28 pages)*
- *Module 8 – Building Alliances and Partnerships (June 2011. 53 pages)*

In Year 1, SUM II also launched its Technical Briefs series, completing the first three briefs in May 2011:

- *Technical Brief #1: CSO Leadership in the HIV Response – A Vision of Change (May 2011)*
- *Technical Brief #2: Fully Effective HIV Programs and Services – Addressing Stigma and Discrimination (May 2011)*
- *Technical Brief #3: Volunteers – A Backbone of HIV Services (May 2011)*

An additional ten briefs were produced by May 2012:

- *Technical Brief #4: Jakarta and East Java – Strengthening Community Readiness in the HIV Response (October 2011)*
- *Technical Brief #5: CSOs and the HIV Response – Assessment Results Point to Strengthening Organizational Performance (October 2011)*
- *Technical Brief #6: CSOs and the HIV Response – Moving Toward a Vigorous Civil Society (October 2011)*
- *Technical Brief #7: CSOs and Local Government – Creating an Enabling Environment for Successful Partnership October 2011)*
- *Technical Brief #8: SUM at the Indonesia National AIDS Conference – Skill-building Workshops Introduce New Assessment Tools (October 2011)*
- *Technical Brief #9: CSO and District Partners Prepare to Apply the RETA Tool – Highlights the Role Civil Society Can Play in National and Local Decision Making (October 2011)*
- *Technical Brief #10: Papua (January 2012)*
- *Technical Brief 11: How to Get the* Whole *of Local Government behind the HIV Response (February 2012)*
- *Technical Brief #12: How to Get the Private Sector Behind the HIV Response(February 2012)*

- *Technical Brief #13: CSO Capacity Building – USAID SUM II Takes Training and Coaching to the Workplace (May 2012)*

The intent of these technical briefs is to provide national, provincial and district partners in the HIV response with documented lessons, learning and recommendations gained through countless interviews, focus groups, workplace training sessions, and program planning and implementation – all carried out with CSO staff and leaders from most-at-risk populations, and with officials of provincial and district departments of health, AIDS commissions, and other local government departments.

In Year 1 SUM II began designing the USAID SUM website, launching it in October 2011 *(www.sum.or.id).* By the end of Year 2 it has been visited by more than 4500 visitors.

In Year 2, SUM II also launched its Success Stories series (see SUM website).

This SUM Project Monitoring & Evaluation Report reviews Year 2 progress in several key areas. In addition, this report includes recommendations for Year 3 – recommendations that have already been incorporated into SUM I and SUM II Year 3 Work Plans. Areas highlighted in this M&E report include:

- Implementation Progress in Year 2
    - ERA and OP/TC baseline findings
    - FSW baseline survey results
    - Disbursement of CSO grants
    - Disbursement of grants to local TA provider organizations
    - Recommendations for Year 3
- Capacity Building Achievements in Year 2
    - Organizational performance and technical capacity by CSO, including staff trained
    - Other stakeholders trained by organization/office
    - QA/QI achievements and systems developed and/or strengthened
    - CSO leveraging of funds
    - Data quality
    - Recommendations for Year 3
- Program and Population Results
    - CSO performance against Year2 targets
    - District performance against Year 2 targets
    - CSO annual survey results
    - Recommendations for Year 3

IMPLEMENTATION PROGRESS

1. ERA and OP/TC Baseline Findings

This section on implementation progress highlights the findings of two SUM Project baselines – the *Expanded Readiness Assessment (ERA),* which determines community readiness in the HIV response, and the *Organizational Performance and Technical Capacity (OP/TC Assessment),* which determines CSO capacity in key organizational and technical areas.

Expanded Readiness Assessment (ERA)

Fifteen ERAs were conducted in DKI Jakarta and East Java in Year 1 of SUM, and in Year 2 twenty-seven ERAs were conducted in Papua, Riau Islands and North Sumatra. ERA summary of findings by province are included below. Multiple stakeholders participated in the ERAs, including representatives of MARPs, CSOs, brothel working groups (*pokja lokalisasi*), health service providers, city and district health offices, city and district AIDS commissions, the provincial AIDS commission, and Global Fund sub-recipients and sub-sub recipients. The assessment is a semi-structured questionnaire applied with a highly participatory, focus group approach, enabling stakeholders to collectively measure their community's level of readiness in the HIV response using six dimensions:

1. MARPs' knowledge of HIV and AIDS
2. Community knowledge about HIV and AIDS efforts
3. Existing HIV and AIDS prevention efforts
4. Resources tied to HIV and AIDS prevention efforts
5. HIV and AIDS related regulations and policies
6. Leadership

Ultimate Goal in the District HIV Response Stage 9 – High Level of Community Ownership

- Recognize leaders in most-at-risk communities as focal points in HIV and AIDS prevention activities and involves them in ongoing program evaluation
- Promote local government, CSO and private sector partnerships in the HIV response
- Put in place supportive local ordinances and policies
- Address stigma and discrimination across departments of local government
- Delineate district-wide scaling-up of HIV services and prevention programs (see the Comprehensive Package of Services, USAID SUM Program Implementation Manuals)
- Close funding gaps (from local government budget)
- Target most-at-risk communities as per the 2011 IBBS (Clear targets are developed together with representatives of MARPs.)

Each of these six dimensions is assessed and scored against nine stages of readiness:

Stage 9: High Level of Community Ownership
Stage 8: Confirmation/Expansion
Stage 7: Stabilization

Stage 6: Integration
Stage 5: Advanced Implementation
Stage 4: Implementation
Stage 3: Initiation
Stage 2: Preparation
Stage 1: No Awareness

The ultimate goal for each community is to reach Stage 9, High Level of Community Ownership (see above text box).

Organizational Performance and Technical Capacity (OP/TC) Assessment

In Year 1 of SUM, fifteen OP/TC assessments were conducted with CSOs working in the HIV response in Jakarta, Malang and Surabaya. In Year 2, six OP/TC assessments were conducted with CSOs in Papua. The purpose of the OP/TC assessment was to serve as a baseline for SUM and the CSO to monitor improvements in the organization's capacity over time.

The OP/TC assessment process proved to be very SUM-staff labor intensive, however, which slowed the grant disbursement process. Moreover, SUM II's approach to CSO capacity building at the start of Year 2 was to shift from the traditional classroom-based training of previous programs to a more intensive program of workplace-based, on-the-job training, coaching, and systems development. This approach made the OP/TC assessment process redundant, since SUM local TA providers are on-site working in partnership with CSOs to tailor capacity building to the specific needs of the CSO. The decision was made to discontinue the OP/TC assessment approach. Summaries of the OP/TC assessments for DKI Jakarta, East Java and Papua are provided below.

DKI Jakarta

Expanded Readiness Assessments (ERAs): The ERA for DKI Jakarta was conducted in Year 1 of SUM. It showed that out of eight communities in the targeted intervention areas, only two communities were at the advanced implementation stage, with the others at the implementation stage (see adjacent text box).

These levels of readiness mean that HIV/AIDS is recognized as a problem but efforts to address this issue are still limited. It indicates that further work is needed to increase 1) MARPs' knowledge regarding the correct modes of HIV/AIDS transmission and prevention; 2) access to HIV care as well as the quality of each type of care; 3) MARPs' involvement in HIV/AIDS program planning and evaluation; 4) supportive regulations and policies related to HIV/AIDS prevention efforts; and 5) resources (people, money, time and space) to ensure the continuation of HIV/AIDS prevention programs in each area. Also key to strengthening the HIV response are the changing of local regulations regarding prostitution, the exchange of clean needles and condom distribution, as well as support to MARPs, establishment owners and pimps/*mami*, so they are not harassed or prosecuted when trying to adopt and/or support the proper HIV risk reduction strategies.

Jakarta

Stage 5: Advanced Implementation

- IDU communities in West and North Jakarta
- IDU communities in Central and South Jakarta

Stage 4: Implementation Stage

- IDU communities in East Jakarta
- FSW communities in West Jakarta
- FSW communities in East Jakarta
- Transgender communities in Jakarta
- MSM communities in West, South and Central Jakarta
- MSM communities in East and North Jakarta

Organizational Performance and Technical Capacity (OP/TC) Assessments: The standout challenge identified by the OP/TC assessment process across the eight CSOs[5] working in the HIV response in Jakarta is how to transcend project-supported management systems to CSO-owned systems that enable the organization to develop, strengthen and succeed over time. The OP/TC assessment process made clear that the scale-up for most-at-risk populations requires a new paradigm for CSOs, one in which the CSO is effectively managing sources of funding with its own program and financial management systems and where its own strategic priorities – including sustainability – drive program development, decision-making and day-to-day operations.

Building capacity in finance systems and management was a development need identified in the CSOs that SUM II is partnering with in DKI Jakarta. SUM II's workplace-based, on-the-job training, coaching and systems development in Year 2 focuses on core requirements to maintain the books and records of a non-profit organization with basic bookkeeping needs – from establishing an accounting function and implementing an accounting system to generating financial statements. A second priority need with the CSOs in DKI Jakarta was strategic planning. More than any single set of skills, strategic thinking and planning empowers an organization – its leaders, staff and volunteers – to see opportunities and be entrepreneurial, to build strong programs, and to continuously find new and better ways of doing business.

[5] See Appendix B, Year 1 and Year 2 CSO Partners

CSOs scored higher in technical capacity and credited the predecessor USAID ASA project in the development of solid knowledge and skills in HIV-AIDS prevention and care, and STI, MMT, condom promotion/distribution, and NSEP.

East Java

Expanded Readiness Assessments (ERAs): The ERA for East Java was also conducted in Year 1 of SUM. It showed that out of seven communities in the targeted intervention areas, only two communities were at the advanced implementation stage, with the others at the implementation stage (see adjacent text box).

East Java

Stage 5: Advanced Implementation

- MSM communities in Malang
- FSW communities in Malang

Stage 4: Implementation Stage

- IDU communities in Surabaya city
- MSM communities in Surabaya city
- Transgender communities in Surabaya city
- FSW communities in Sememi, Surabaya city
- IDU communities in Malang

ERA findings showed that several HIV/AIDS-related services were available for MARPs, but the accessibility and the quality of each service needed improvement. Inadequate leadership, limited resources related to HIV/AIDS prevention efforts, non-supportive regulations and policies, lack of MARPs' involvement in program planning, and unclear targets and indicators to measure the impact of the program were observed across the seven communities in East Java. Moreover, comprehensive HIV/AIDS prevention programs in most communities were limited and negative attitudes from local religious groups and community leaders towards most-at-risk populations persist. The findings also showed that even though MARPs have high knowledge of HIV transmission and prevention, as well as perceived susceptibility of HIV risk, misconceptions on how HIV is transmitted and improper adoption of HIV/AIDS risk reduction strategies still existed.

Organizational Performance and Technical Capacity (OP/TC) Assessments: Similar to the Jakarta CSOs, the OP/TC assessment process conducted with the seven East Java CSOs[6] working in the HIV response identified financial management systems and strategic planning as the priority organizational improvement areas. Core financial management on-the-job training, coaching and systems development focused on establishing a chart of accounts tailored to the CSO, accrual and cash based accounting, budgeting, financial statement preparation and financial policies and procedures. Strategic planning focused on identifying strategic priorities for the CSO, and developing program plans for HIV services – with clear objectives and milestones, resource allocation plans, and indicators. Similar to DKI Jakarta, CSOs in East Java scored higher in technical capacity – HIV/AIDS prevention and care, and STI, MMT, condom promotion/distribution, and NSEP.

[6] See Appendix B, Year 1 and Year 2 CSO Partners

Papua

Expanded Readiness Assessments (ERAs): In Year 2 SUM launched its Papua program. SUM partnered with Cenderawasih University (UNCEN) to conduct the *Expanded Readiness Assessment* (ERA) to determine the level of preparedness of seven most-at-risk communities at targeted intervention sites. UNCEN conducted the ERAs in four geographical areas of Papua – Jayapura city, Jayapura district, Jayawijaya district, and Mimika district. Most-at-risk populations included female sex workers (FSWs), men who have sex with men (MSM), transgender people (TG), high-risk men (HRM), and adult indigenous men and women.

Papua

Stage 3: Initiation

- Transgender communities in Jayapura city
- FSW communities in Jayapura city
- MSM communities in Jayapura city
- FSW communities in Tanjung Elmo, Jayapura district
- Adult indigenous women communities in Jayawijaya district
- Adult indigenous men communities in Jayawijaya district
- FSW communities in Mimika district

The results show that all seven communities in the targeted intervention areas were at the initiation stage (see above text box). A central message from the results is that improvement of HIV/AIDS-related policies and services among MARPs in Papua is needed. Given Papua's unique characteristics (including the indigenous population) that differ from other parts in Indonesia, special HIV/AIDS programming is required that considers the contextual situation of each MARP. The results also clearly showed that extensive program coverage is needed to stop the sharp increases in HIV among Papuans. Without this expanded exposure, including to the highland areas, improvements in knowledge of STIs and HIV/AIDS and the adoption of HIV risk reduction behaviors will be insufficient. Parties acknowledge that funding to combat HIV/AIDS is adequate, yet coverage remains low and programming is lacking that addresses the unique characteristics of Papua's most-at-risk populations.

Organizational Performance and Technical Capacity (OP/TC) Assessments: In October 2011 UNCEN conducted OP/TC assessments of six potential CSO partners.[7] Overall results show that the six CSOs need assistance to strengthen strategic and program planning, leadership and management development, advocacy, and financial systems and management. Most of the six CSOs were also understaffed and lack a qualified accountant. Technical areas for improvement included monitoring and evaluation (all lack a monitoring and evaluation officer) and BCI (behavior change intervention). Although the six CSOs have the ability to reach their target population, their skills in BCI need strengthening. Most have established networks to service providers but lack support from the District AIDS commission (DAC) and local government departments. This support is needed to fully regulate the referral system between CSOs and service providers. The six CSOs also needed to conduct mapping to update information about their target populations and sharpen their outreach strategies and work plans.

[7] See Appendix B, Year 1 and Year 2 CSO Partners

Riau Islands

Expanded Readiness Assessment (ERA): In Batam City, ERAs included direct and indirect FSWs, high-risk men (HRM), IDUs, MSM and *Waria*, whereas in Tanjung Pinang City and Bintan District, only direct FSWs and high-risk men were included in the assessments (see adjacent text box).

Riau Islands

Stage 4: Implementation

- IDU communities in Batam city
- TG communities in Batam city
- MSM communities in Batam city
- FSW communities in Sintai, Batam city
- FSW communities in Nagoya, Batam city
- FSW communities in Batu 15, Tanjung
- FSW communities in Batu 24, Bintan district

Stage 3: Initiation

- HRM communities in Batam city
- HRM communities in Tanjung Pinang city

Stage 2: Preparation

- HRM communities in Bintan district

IDU and *Waria* communities showed a higher state of readiness than MSM, direct or indirect FSWs and HRM in Batam City. Community knowledge of HIV/AIDS scored highest followed by community climate, especially among *Waria*. Knowledge of local program efforts, leadership, related resources, and policies that address HIV/AIDS are less known. Scores are lowest for HRM (for example, shipyard workers, and taxi and *ojek* drivers), typically the clients of FSWs. In Tanjung Pinang City and Bintan District, HRM are also less knowledgeable among all six dimensions than FSWs in brothels. The levels of awareness and knowledge in Batam City among key populations other than HRM are lower than in Jakarta, Surabaya or Malang but still in the "implementation" stage of readiness. The same applies to brothel-based FSWs in Tanjung Pinang City and Bintan District. However, HRM are in the "initiation" stage in Batam and Tanjung Pinang cities and in only the "preparation" stage in Bintan District. The results among high risk men suggest that most who are clients of FSWs do not use condoms and FSWs will find it difficult to demand their clients use condoms.

CSO Partners: SUM conducted the CSO selection workshop on March 22, 2012, in Riau Islands. Representatives from the provincial AIDS Commission and from AIDS Commissions of Batam and Tanjung Pinang Cities, and Bintan District attended, as did representatives from the provincial Health Office and Health Offices of Batam and Tanjung Pinang Cities, and Bintan District. NGO forums from the province, cities, and district also attended. One CSO will cover the two brothels in Tanjung Pinang City and Bintan District, whereas three CSOs will cover the key populations in Batam.[8]

North Sumatra

Expanded Readiness Assessments (ERA): In Medan City, ERAs included IDUs, *Waria*, MSM, indirect FSWs, and HRM. In Deli Serdang District, ERAs included IDUs, brothel-based FSWs, and

[8] See Appendix B, Year 1 and Year 2 CSO Partners

HRM. In Serdang Bedagai District, ERAs included brothel-based FSWs and HRM (see adjacent text box).

A pattern similar to the cities and district in the Riau Islands emerged. Readiness is highest for IDUs and lowest for HRM. The recent IBBS (MOH 2012) has shown the presence of HIV among HRM in North Sumatra, particularly among seafarers, dock workers and truck drivers. HIV programs for these groups need clarity. Defining the size and characteristics of the HRM populations will assure clear targets and indicators. Outreach and HIV/AIDS services can be provided once the hotspots where these men congregate are identified. For example, the ERA shows knowledge of HIV/AIDS is moderately high for IDUs in Medan and Deli Serdang but knowledge is low for HRM in Medan, Deli Serdang and Serdang Bedagai. Also, readiness is generally higher for indirect FSWs than for brothel-based FSWs.

North Sumatra

Stage 5: Advanced Implementation

- IDU communities in Medan city

Stage 4: Implementation

- TG communities in Medan city
- FSW communities in Medan city
- IDU communities in Deli Serdang district

Stage 3: Initiation

- MSM communities in Medan city
- HRM communities in Medan city
- FSW communities in Deli Serdang district
- FSW communities in Serdang Bedagai district

Stage 2: Preparation

- HRM communities in Deli Serdang district
- HRM communities in Serdang Bedagai district

CSO Partners: SUM II is working with four partners in North Sumatra – three CSOs and the NGO Forum.[9] The NGO Forum will assist SUM II with CSO capacity building in advocacy and building partnerships with government and other stakeholders. They will also assist with convening HIV response coordination meetings, and with developing CSO advocacy strategies.

2. FSW Baseline Survey Results

A baseline survey[10] on female sex worker behavior, funded by USAID SUM II, was conducted in 2012 by the University of Indonesia's Department of Epidemiology in the Faculty of Public Health. The purpose of the survey was to supplement the 2011 IBBS for two locations it did not cover, areas selected by SUM for intervention – Perumpung in East Jakarta and Moroseneng in Surabaya. The survey's objectives were as follows:

1. To know the characteristics of several key indicators:
    - Socio-demographic characteristics
    - Sexual behaviors
    - HIV related knowledge, attitudes and practices

[9] See Appendix B, Year 1 and Year 2 CSO Partners

[10] *Baseline Survey of Female Sex Worker (FSW) Behavior in Perumpung (Jakarta) and Moroseneng (Surabaya), Year 2011.* Department of Epidemiology, Faculty of Public Health, University of Indonesia, in Collaboration with USAID and SUM II. July 2012. 59 pages.

- HIV risk reduction practices
- Experience of voluntary counseling and testing (VCT)
- Exposure/access to available HIV/STDs services

2. To strengthen partnership and technical capacity of local NGOs/CSOs in behavioral survey methodology and data interpretation needed to plan intervention programs.

This cross-sectional survey was done by using the same questionnaire (for target populations of FSWs) from the 2011 IBBS.[11] The total sample size was 504 FSWs, which was more than the minimum sample size of 400. Some of the key survey highlights are included in Appendix A.

3. Disbursement of CSO Grants

Disbursements of Grants to SUM CSO Partners

Grants to CSOs in DKI Jakarta and East Java expired at the end of Year 2 and are being extended for Year 3, except for Layak and Sadar Hati, which have been suspended. The table below lists grants, actual or estimated, for year three for principal and developing CSOs.

Principal CSOs[12]

PROVINCE	CSO	BUDGET		TARGETS			
		IDR	USD	MARPs	HCT	PLHIV	STI
East Java	PARAMITRA	880,288,000	97,810	675	525	30	575
East Java	GAYA NUSANTARA	815,025,875	90,558	4,264	626	20	626
East Java	GENTA	838,762,000	93,196	600	600	35	600
Jakarta	YKB	1,101,627,481	122,403	2,413	1,639	141	1,771
Jakarta	KARISMA	1,148,552,500	127,617	2,900	1,465	730	140
	TOTAL	4,784,255,856	531,584	10,852	4,855	956	3,712

[11] MOH, 2012

[12] Current recipient of SUM II grant and TA or well-established CSO with proven track record whose management has demonstrated responsiveness to OP training, understand barriers to improved organizational performance, and taken steps to make changes and improve systems.

Developing CSOs[13]

PROVINCE	CSO	BUDGET		TARGETS			
		IDR	USD	MARPs	HCT	PLHIV	STI
Jakarta	YSS	825,577,200	91,731	1,362	681	68	681
Jakarta	YIM	857,813,059	95,313	4,750	1,400	210	280
Jakarta	LPA	810,963,067	90,107	5,600	1,500	225	300
Jakarta	ATMAJAYA	922,534,249	102,504	2,355	400	200	100
Jakarta	BANDUNGWANGI	656,103,710	72,900	1,213	243	12	607
East Java	PERWAKOS	664,952,750	73,884	950	513	80	855
East Java	ORBIT	748,925,300	83,214	600	100	75	100
East Java	IGAMA	747,080,220	83,009	4,050	775	40	750
Papua*	PKBI PAPUA	998,228,100	110,914	655	205	32	428
Papua*	YPPM	880,018,500	97,780	8,360	2,090	61	2,090
Papua*	YHI	967,939,000	107,549	789	316	9	631
Papua*	YCTP	1,435,580,000	159,509	11,077	1,511	37	1,511
Papua*	TALI	981,210,000	109,023	21,220	509	15	509
Papua*	YUKEMDI	1,097,005,000	121,889	16,280	912	43	968
Riau Islands	Bentan Serumpun	596,004,807	66,223	281	281	28	281
Riau Islands	Kompak	674,860,096	74,984	400	80	620	80
Riau Islands	Embun Pelangi	796,152,500	88,461	2,384	482	7	482
Riau Islands	Gaya Batam	801,315,000	89,035	1,300	780	61	780
Riau Islands	Lintas Nusa	1,158,568,620	128,730	2,355	1,295	98	1,295
North Sumatera	Galatea	849,574,985	94,397	350	245	95	125
North Sumatera	Human Health Organization	829,271,264	92,141	350	245	8	350
North Sumatera	Gerakan Sehat Masyarakat	793,964,025	88,218	2,481	1,294	240	1,790
	TOTAL	19,093,641,452	2,121,516	89,162	15,857	2,264	14,993
* Grants in Papua period is Feb 15,2012-Feb 14, 2013							

See Appendix B for more information on USAID SUM CSO partners.

Disbursements of Grants to Local TA Providers

The following table summarizes the disbursement of grants to SUM II local TA providers. In Year 2, three local TA organizations supported CSO capacity building program: Penabulu, Satunama, and Circle Indonesia.

Province	TA Providers	Period	Budget		Period	Budget	
			IDR	USD		IDR	USD
Jakarta	Penabulu	Aug 15, 2011- Aug 14, 2012	681,090,000	80,128	Aug 15, 2012-Aug 14, 2013	1,477,000,000	164,111
Jogjakarta	Circle Indonesia	Nov 15,2011-Nov 14, 2012	1,290,744,760	151,852	Nov 15, 2012-Nov 14, 2013	2,283,004,760	253,667
Jogjakarta	Satunama	Nov 15,2011-Nov 14, 2012	975,205,000	114,730	Aug 15, 2012-Aug 14, 2013	1,430,160,000	158,907
Jogjakarta	Survey Meter				Aug 1, 2012-Jul 31, 2013	3,584,860,000	398,318
Papua	KIPRa				Aug 1, 2012-Jul 31, 2013	1,767,155,000	196,351
	TOTAL		2,947,039,760	346,711		10,542,179,760	1,171,353

[13] Current recipient of SUM II grant and TA or established CSO with experience delivering HIV services effectively. (TA for organizational performance and technical capacity will be limited but focused on monitoring and evaluation.)

4. Recommendations for Year 3[14]

Following completion of ERAs in DKI Jakarta, East Java, Papua, Riau Islands and North Sumatra, and OP/TC assessments of CSOs in these provinces, except North Sumatra, USAID and SUM II cancelled further implementation of both assessments. The ERAs provided valuable baseline information on the preparedness of targeted district stakeholders and the OP/TC assessments provided comprehensive guidance on the strengths and weaknesses of the CSOs. However, the level of effort and time spent implementing the assessments exceeded their value to SUM II in achieving its objectives.

In Year 3, SUM II will continue its efforts to strengthen the engagement of civil society organizations (CSOs) in the HIV response, underscoring the need for multiple partners and stakeholders to engage collaboratively together if the response to HIV, ultimately, is to be successful. Although the focus is centered on CSOs, SUM will provide TA within the larger context of partnership and stakeholder engagement in a district-wide HIV response. Networking and building partnerships are critical leadership functions. They are especially critical in bringing collective leadership to the district-level HIV response, in mobilizing the HIV response, and in advocacy efforts.

Recommendations for Year 3 had the benefit of the USAID Management Review of SUM conducted March 20-April 30, 2012. Specific to SUM II are several recommendations – to reinforce approaches already underway or to modify or change some approaches. In response to "Implementation Progress" SUM II recommends:

1. *Restructuring and increasing SUM II staff to support more intensive capacity building of CSOs.*

SUM II will eliminate one key position—Senior Technical Expert for HIV/AIDS Capacity Building—and propose the Senior Technical Expert for Organizational Performance as SUM II's Senior Program Coordinator. In addition SUM II proposes adding a National Capacity Development Officer and a Regional Capacity Development Officer in West Papua and in Riau Islands; an Information and Communications Technology Specialist; and an additional Grants Manager, Grants Management Assistant, and a Finance and Administration Assistant for the Jakarta regional team.

2. *Expand SUM II's approach to CSO capacity building, especially to Tanah Papua, that takes training, coaching and systems development to the CSO workplace, and relocate SUM II staff in Papua's targeted cities and districts and post staff in targeted cities and districts in West Papua.*

[14] See USAID SUM I and SUM II Year 3 Work Plan for specific details on each recommendation outlined in this section.

Our current TA providers' management capacities in more far flung provinces are limited. SUM II will therefore in Year 3 continue to identify TA organizations, especially organizations in the targeted provinces, to support our CSOs, understanding that these organizations may require initial technical input from our current TA providers based in Jakarta and Yogyakarta.

SUM II will relocate a Regional Capacity Development Officer to Wamena, Jayawijaya and Mimika, and post a Capacity Building Officer to either Sorong City or Manokwari City following expansion to these cities in West Papua. The Regional Coordinator, a Regional Capacity Building Officer and Accountant will remain at the regional head office in Jayapura.

CAPACITY BUILDING ACHIEVEMENTS

1. Organizational Performance – CSOs and Other Stakeholders

The overarching finding from the 21 OP/TC assessments in DKI Jakarta, East Java and Papua is that civil society organizations were being asked to scale-up their HIV services, but most lack the organizational effectiveness to do so. Key outcomes of capacity building programs for any organization are achievement and sustainability. CSOs without even basic capacity to manage their own finances stand little or no chance with future funders.

SUM II Capacity Building Approach

SUM II at the beginning of Year 2, believing that traditional classroom-based training has not resulted in improved CSO organizational capacity, launched an intensive workplace program of on-the-job training and coaching, in partnership with local organizational performance (OP) practitioners (see above text box).

USAID SUM II Capacity Building Partners

Yayasan Penabulu – TA to CSOs to build financial management capacity. (www.penabulu.or.id)

Circle Indonesia – TA in organizational performance to CSOs in Jakarta and North Sumatra. (www.circleindonesia.or.id)

Yayasan SATUNAMA – TA in organizational performance to CSOs in East Java and Riau Islands. (www.satunama.org)

KIPRa Papua – TA in organizational performance to CSOs in Papua. KIPRa specializes in working with Papuan indigenous communities. (www.direktori-perdamaian.org/english/org_detail.php?id=1095)

SurveyMETER – TA to CSOs to build capacity in monitoring and evaluation. (www.surveymeter.org)

Yayasan Spiritia – TA to build capacity of catalyst organizations to deliver active outreach about HIV, testing and post-testing practices. (www.spiritia.or.id)

This approach to capacity building that brings local TA providers to the CSO workplace enables SUM II to tailor capacity building to the specific needs of the CSO. On-the-job training is a higher quality and higher impact approach over traditional regional and national training courses that bring leaders and managers from several CSOs together and away from their offices and work teams. SUM II's workplace training includes a combination of intact team sessions and individual on-the-job

training. It is real-time training to launch a new system and to practice and strengthen new skills that will make a difference that very day.

Coaching is the centerpiece of SUM II's approach. Skill-building and steps to bring changes happen incrementally in a workplace, especially in the application of a new system – for example, how to analyze information the new system is generating, and how to make changes or take decisions in response to the analysis. Intensive on-the-job coaching makes it possible to reinforce new skills and behaviors, and lock-in the improvements that result in effective HIV programs and greater coverage of most-at-risk populations.

For each new financial, management or program system, the OP specialist works with CSO managers to design the system based on real needs. Emphasis is on *practical* and *easy to use*. By participating in the design of a new system, managers and staff are better able to understand the changes they will be part of to get the system integrated into the everyday work of the organization – new procedures, new skills and different behaviors. For more detailed information on the CSO package of TA support see Appendix C; and see Appendix D for more details on workplace training and coaching in financial management and organizational development.

Principle CSOs

Now, at the end of Year 2, five SUM CSOs partners in Jakarta and East Java – having received intensive workplace training, coaching and systems development – are designated as *principal* CSOs (see section 2.2 above). It means that their management and staff have demonstrated responsiveness to OP training, understand barriers to improved organizational performance, and have taken steps to make changes and improve systems; and the Board of Directors actively carries out its responsibilities to the organization, especially in its responsiveness in addressing the organization's challenges.

In Year 3, SUM II will offer to *principal* CSOs additional funding and technical assistance (TA) support to expand coverage and further strengthen programs. On-the-job training and coaching for *principal* CSOs will focus on ways to tap community and social activities of most-at-risk populations – to expand programs and coverage by recruiting volunteers and soliciting monetary and in-kind contributions; and on the way to build partnerships with other projects in the cities and districts that serve MARPs and PLHIV so that HIV services are mainstreamed in these activities. *Principal* CSOs will partner with developing CSOs in advocacy to local government for increases in local funding for HIV services.

SUM II TA partners will keep building the capacity of *principal* CSOs in DKI Jakarta, East Java, Papua, West Papua, Riau Islands and North Sumatra to enable them to become *local capacity building coaches* to developing CSOs (financial, management and program skills and systems). Local TA partners now operate as full SUM II team members – engaging in SUM II strategy development and implementation planning, and learning and sharing OP best practices. They

are extending the reach of SUM II's capacity building program and making possible the intensive program of training and coaching in the CSO workplace.

At the end of Year 2, USAID SUM II CSO partners numbered 7 in DKI Jakarta (one CSO suspended[15]), 7 in East Java (one CSO suspended), 6 in Papua, 4 in North Sumatra (grants pending) and 5 in Riau Islands (grants pending). TA partners and the approaches they bring to SUM II capacity building will do much to enhance CSO visibility and credibility in the district HIV response and strengthen abilities to attract, create, and sustain new resources, especially resources based in local communities.

DKI Jakarta and East Java – Financial Management by TA Provider, Penabulu

Penabulu has assisted 15 CSOs to draft and finalize standard operating procedures for financial management and for daily transaction reporting. Workplace focus group discussions (FGDs) were conducted to finalize standards with CSOs that have completed drafts. In the coaching process, emphasis was on the development of policies and procedures based on existing patterns of work, internal control systems, and organizational structure at each institution. During the FGDs the draft finance SOP were presented and reviewed again by all units of each CSO to make final revisions. In the next step, CSO Boards and Directors introduced and oriented their staff to the standards. All CSOs in DKI Jakarta and East Java have either final drafts of SOP or completed SOP.

In addition to assisting in the development of financial standard operating procedures, Penabulu has increased the capacity of the financial officers by introducing a special curriculum and topics related to the financial management standards of non-profit organizations. Topics included budgeting, bank account management, accounting, recording of assets, financial information, and financial statements according to PSAK 45. Presentation of topics differed depending on each CSO's specific needs. Penabulu has created a "Consultation Support Unit" that forwards articles on non-profit financial management every Tuesday and Thursday via a SUM/CSO mailing list. Results are verified by a "Monthly Mentor Report Sheet," as well as the documents produced by CSOs, such as drafts of Policies and Procedures, and drafts of Financial SOP per CSO. Please see the tables in Appendix D for details.

DKI Jakarta and East Java – Organizational Development by TA Providers Circle and Satunama

Circle and Satunama on-the-job training and coaching has led to CSOs in Jakarta and East Java developing or revising legal documentation for registration with the government as NGOs. Most have finalized the process but some are still pending. All CSOs, except, Sadar Hati, have developed strategic plans, and all have prepared action plans for advocacy and community

[15] SUM II disbursement of grant funds and TA is stopped because CSO management did not demonstrate sufficient responsiveness to organizational and technical capacity building training/coaching. (However, the CSO may participate in TA, especially monitoring and evaluation.)

mobilization except Layak and Sadar Hati. Layak's and Sadar Hati's grants are suspended. Please see the tables in Appendix D for details.

Papua – Financial Management and Organizational Development by SUM II

To initiate implementation by CSOs in Papua while waiting for Penabulu and Satunama to expand their scopes of work and negotiate a grant with KIPRa, SUM II staff has aggressively provided TA to the CSOs. The TA has focused on detailed implementation plans, standard operating procedures for recruitment and staffing, basic financial and program recordkeeping and reporting, HCT and STI service coverage and leveraging funds. Please see the tables in Appendix D for details.

Capacity Building in Monitoring and Evaluation by TA Provider SurveyMETER

SUM revised the CSOs' database introduced with USAID funding prior to SUM. Revisions were made in collaboration with civil society Global Fund Principal Recipients. Installation of the new database and training at CSOs was conducted in the second quarter of year 2.

SUM conducted a Data Quality Audit in the third quarter and USAID conducted one during the fourth quarter of Year 2. Both audits found errors in recordkeeping and reporting related to the database program used by CSOs, as well as a lack of knowledge regarding protocols. SUM II subsequently visited all CSOs in DKI Jakarta to further investigate the issues. As a result, SUM II is proposing to change replace the current database program with Epi-Info so that we can train and coach CSO staff, not only in data entry, but in managing the tool, analyzing the data to solve problems, and update the tool as needed. A consultant who is expert in NGO M&E and Epi-Info will assist SUM II to make the transition.

During the last quarter of Year 2, SUM II negotiated a scope of work and budget for SurveyMETER to assist each CSO to build their M&E knowledge and skills based on their current status. Because CSOs are developing their organizational capacity with assistance from other SUM partner TA organizations, SurveyMETER will coordinate with these other institutions to harmonize the content of M&E functions so that CSOs will have ability to monitor and evaluate their institutional and programmatic performance. Specifically, SurveyMETER will implement activities which will support the following objectives:

1. To improve monthly record keeping and reporting by CSOs—accuracy and timeliness
2. To build the capacity of CSOs to collect, analyze, and interpret data for more cost effective implementation and reporting, including mobile phone technology
3. To carry out periodic qualitative assessments (including, but not exclusively, focus group discussions) of MARP clients to identify barriers to service utilization and to build up CSO capacity with assistance from SUM II
4. To manage CSO web-based database and reporting
5. To conduct semi-annual surveys of CSO intervention sites

6. To assist government departments and other stakeholders as requested.

Capacity Building for CSOs and Other Stakeholders – Resource Estimation Tool for Advocacy (RETA)

AIDS Commissions from Malang District and Surabaya City participated in RETA workshops for CSOs in 2nd quarter of Year 2 and requested technical assistance from SUM II to estimate their resource needs to advocate for and implement a comprehensive, 5-year HIV program in their district and city using the Resource Estimation Tool for Advocacy. The workshops were opened by the Vice *Bupati* in Malang District and by the Vice Mayor in Surabaya City. Fourteen government institution representatives (SKPD) from Malang and 14 from Surabaya participated. Not all representatives brought the necessary data to the workshops so follow-up was required for more accurate estimations but awareness of shortcomings in the governments' programs was made known. Moreover, many departments did not demonstrate an understanding of how their HIV programs should be integrated into their program portfolios and budgets.

SUM II will need to continue to work with these government departments to improve their planning and budgeting of HIV services. Budgets should be reviewed by *BAPPEKO (Badan Perencanaan Pengembangan Perkotaan*) and *Bina* Program before sending to the legislatures. And the approved budgets should go to government departments and organizations as *Dana Hibah*. By learning more about this mechanism, access to the process would improve and the potential for leveraging funds would also improve through APBD.

Following these exercises in Surabaya City, the AIDS Commission and SUM Program were invited to participate in SKPD's *Musrembang (Musyawarah Perencanaan Pembangaunan)* to address priority programs. The *BAPPEKO's* presentation revealed that the HIV program or corresponding MDG were not a priority in 2013. Therefore, the AIDS Commission and SUM II are working closely with other government institutions (SKPA), especially *Badan Anggaran*, to provide up-to-date information on HIV issues and the comprehensive package of services necessary to halt the epidemic.

2. Technical Capacity – CSOs and Other Stakeholders

BCI Training

SUM BCI training was completed for SUM-supported CSOs and other key local implementing partners in Jakarta and East Java in second quarter of Year 2 by SUM I and in Papua in the fourth quarter by SUM II and I. Field training and coaching was then undertaken in third quarter in Jakarta and East Java by teams consisting of SUM staff and consultants selected from a pool of BCI Master Trainers that had led the earlier BCI and in Papua by SUM I and II staff. Ten of the 15 CSOs in Jakarta and East Java (excluding the 5 CSOs working with IDUs that will be served by

different group mentors) each received a two-day coaching visit by a mentor who was matched to the CSO with regard to skills, expertise and CSO needs. Feedback received from the mentors as to CSO strengths and areas for further development were compiled, analyzed and used to guide follow-on TA and coaching. Regularly scheduled coaching will be undertaken quarterly, with additional coaching as needed. Training of CSOs working with IDUs was undertaken in the fourth quarter of Year 2. Coaching at CSOs in Papua continues in the first quarter of year 3.

Monitoring and Evaluation

To ensure SUM's CSO partners record and report their achievements, in particular information on MARPs reached, HCT, STI services and CST, SUM revised the data formats and database program developed prior to SUM with USAID funding. The database is programmed to facilitate data entry and to identify individuals by ID number to avoid duplication. However, some of SUM CSOs partners in Papua serve key populations—high-risk men and indigenous adults—for which the database program was not designed. SUM has therefore introduced Excel spreadsheets for CSOs in Papua to use for record keeping and reporting temporarily.

In addition, SUM II began working with the CSOs to use qualitative data so they can more accurately and frequently interpret numerical results. In the fourth quarter of Year 2, SUM II continued capacity building activities for CSOs' M&E staff in analysis of qualitative data for more effective management and implementation. Ultimately, the use of both quantitative and qualitative assessments will help CSOs better understand and overcome barriers to implementation and provision of services. CSO M&E staff with assistance from their TA providers will focus on organizational performance, CSO interventions, MARP characteristics that influence their behaviors, health care providers' quality of services, advocacy, and community mobilization.

3. CSO Leveraging of Funds

In Year 2, nine CSOs in DKI Jakarta, East Java and Papua leveraged funds from other sources, greatly exceeding expectations. GFATM was the source of funds in one case; in all others the funds came from district government offices – Welfare, Education, Community Empowerment, Health, or AIDS Commission.

Summary of CSO leveraging of funds

CSO	Amount	Source
DKI JAKARTA		
Bandungwagi	IDR 50,000,000	PNPM (GOI program)
YKB	IDR 100,000,000	DKI Jakarta AIDS Commission
EAST JAVA		

CSO	Amount	Source
PERWAKOS	IDR 168,000,000	Surabaya District Welfare Department
	IDR 4,000,000	Surabaya District Welfare Department (for June-July 2012 nutrition program)
	IDR 27,000,000	East Java Provincial Welfare Department (for PLWA nutrition program beginning in August 2012)
	IDR 18,000,000/year	Bethany Church (housing program for the elderly (waria)
Orbit	IDR 1,371,500,000	GFATM (Sept 2011 – Dec 2012)
Paramitra	IDR 18,000,000	Malang District Welfare Office
	IDR 40,000,000	Malang District Education Office (for a reading program for FSWs)
	IDR 1,400,000,000	GFATM (2011-12)
	IDR 1,100,000,000	GFATM (2012-13)
Genta	IDR 96,000,000	Surabaya District Welfare Office
	IDR 9,000,000	Surabaya District Health Office
	IDR 2,000,000	Surabaya District Community Empowerment Office
IGAMA	IDR 14,700,000	Malang City Health Office
	IDR 50,000,000	Malang City Education office
	IDR 45,000,000	Malang City Welfare Office
PAPUA		
YUKEMDI	IDR 200,000,000	Jayawijaya District AIDS Commission
TALI	IDR 60,000,000	Jayawijaya District AIDS Commission

The major contributing factor to leveraging of funds by CSOs in East Java, and to a lesser extent in Jakarta, is SUM II's introduction of the *Resource Estimation Tool for Advocacy (RETA).* RETA estimates the level of finances needed to scale up HIV programming over a 5-year period, based on population size estimates, local costs of HIV prevention, care, treatment and support programs, and service coverage targets. It was originally developed as a HIV programming tool for men who have sex with men under the USAID Health Policy Initiative in the Greater Mekong and China Program. In Year 1, SUM II adapted the tool so it can be applied to programming for female sex workers, transgender people, and injecting drug users. The bottom-line is that the RETA application provides the evidence to advocate for increased finances for HIV programs.

To introduce RETA and prepare for RETA application, SUM II conducted 3-day training workshops in Surabaya, Jakarta and Malang, held in July-August 2011, for 48 representatives of CSOs, national, provincial, and local AIDS Commissions, and provincial and local health departments. RETA is a consensus building tool when used collectively by partners. For example, as part of the 3-day RETA training workshops participants worked in smaller groups of multiple stakeholders to use their own data on population size estimates, current HIV programming and resources allocation, and their program budgets for determining costs of the HIV services they deliver. It is an exercise that highlights the numerous issues arising from multiple sources of conflicting data, issues that lead to unfortunate mismatches across program

budgets, capture areas (hotspots), and populations for services. Application of the RETA tool provides a fuller picture of the mismatches that continue to undercut the response to HIV in many communities.

In Papua, YUKEMDI and Tali quickly established a working relationship with the District AIDS Commission and District Government as part of initial technical assistance in developing scopes of work and advocacy. RETA will be introduced in year 3 to more accurately frame the resources needed in the district to achieve the program's objectives through a more productive partnership between CSOs and government.

4. Data Quality

HIV/AIDS program performance assessments and future program improvement relies on data that is recorded and reported routinely. The information gained from this data impacts decision making: when the quality of data is poor, decisions and program planning are less effective. Data quality audits (DQAs) review the accuracy and precision of data based on predetermined standard guidelines.

In December 2011 and January 2012, SUM national and regional staff conducted DCAs with 15 CSOs in DKI Jakarta and East Java (see adjacent text box). CSO program managers, M&E staff, field coordinators and 2-3 representatives of the CSO outreach workers participated in the audits.

DATA QUALITY AUDITS

DKI Jakarta

- Yayasan Bandungwangi
- Yayasan Kusuma Buana
- Yayasan Karisma
- Yayasan Layak
- Yayasan Kios Atmajaya
- LPA Karya Bakti
- Yayasan Inter Medika
- Yayasan Srikandi Sejati

East Java

- Yayasan Gaya Nusantara
- Yayasan Genta
- Perwakos
- Yayasan Sadar Hati
- Yayasan Orbit
- Yayasan Paramitra
- Yayasan Igama

Audit findings included:

- Several CSOs using forms developed during the USAID-funded ASA program rather than newly revised forms
- Failure to understand data analysis and interpretation
- No clear guidelines for how to process data and compile reports.

5. Recommendations for Year 3[16]

Recommendations for Year 3 specific to capacity building are highlighted here:

1. *Identify and support principal CSOs to become local capacity building coaches to developing CSOs.*

[16] See USAID SUM I and SUM II Year 3 Work Plans for specific details on each recommendation outlined in this section.

In Year 3 of SUM II, CSOs designated as *principal* CSOs will be offered expanded scopes of work and TA support. SUM II anticipates 2 CSOs in Papua—YCTP and YUKEMDI—will be identified as *principal* CSOs in the third quarter of Year 3 when their annual grants expire. Additional funding to *principal* CSOs will focus on expanding coverage and further strengthening programs. SUM II TA partners will keep building the capacity of *principal* CSOs to enable them to become *local capacity building coaches* to *developing* CSOs and non-SUM II CSOs (financial, organizational management and program development and management). For example, in recent months *Paramitra*, a SUM II grantee in Malang, has provided coaching to a brothel complex working group that it helped establish three years ago. It has 15 members, including village leaders and community workers from two brothel areas in Malang District – Suko and Slorok. *Paramitra's* recent coaching has focused on clarifying internal roles and responsibilities, policy and management agreements, detailed work planning, and advocacy skills. *Paramitra* has also initiated coaching programs with two new community organizations – KK Wawarapa, working with transgender people, and Sekar Arum, working with female sex workers. *Paramitra* says its goal is that these organizations become empowered to leverage local government funds for their programs through their own direct relationships with district government and the Puskesmas.

In years 4 and 5, SUM II will focus TA and a greater proportion of its resources on the *principal* CSOs. Other CSOs may receive support to reach MARPs and refer for services where additional coverage is needed. *Principal* CSOs will be encouraged to support other CSOs, CBOs or FBOs to expand their reach, support private clinics and hospitals to supplement government services, and to provide clinical services themselves.

2. *Continue SUM II's approach to CSO capacity building that takes training, coaching and systems development to the CSO workplace.*

Now, a year in the making, SUM II's intensive program of on-the-job training and coaching, in partnership with local organizational performance (OP) practitioners, is beginning to show results. SUM II will continue its approach to capacity building in Year 3, an approach that takes real-time training, coaching and systems development to the CSO workplace. It is a higher quality and higher impact approach over traditional regional and national training courses that bring leaders and managers from several CSOs together and away from their offices and work teams.

3. *Continue to partner with local TA organizations in providing on-the-job training, coaching and systems development tailored to the specific needs of the CSO.*

SUM II will continue its approach to partner with local TA organizations, and expand TA partners from three to six partners in Year 3. This approach to capacity building that brings TA providers to the CSO workplace is establishing important linkages that over the long term will maximize the sustainability of results. Moreover, local OP practitioners equipped with new knowledge about the HIV epidemic and the challenges of HIV program scale-up bring much needed skill-sets to the HIV response in Indonesia – they are people who not only know how to

build high-performing organizations but also how to create the partnerships and alliances required in scaling-up programs and services.

4. *Improve monitoring and evaluation of performance indicators for CSOs and expand SUM II's approach to capacity building by partnering with SurveyMETER to support SUM II's responsibility for CSO monitoring and evaluation*

In Year 3, SUM II will assume complete responsibility for CSO monitoring and evaluation (M&E), including monthly recordkeeping and reporting, population-based surveys at CSO intervention sites, and qualitative assessments at intervention sites, such as focus group discussions. SUM II will support our M&E staff by issuing a grant to SurveyMETER to provide on-the-job training/coaching to CSOs so they are able to identify obstacles and take action. SUM II will also replace the proprietary database program for CSOs, which is costly to maintain and update, and has hampered CSO staff from learning how to manipulate and analyze data.

SUM II will thoroughly revise the Data Quality Audit to comply with procedures conducted by USAID's audit.

PROGRAM AND POPULATION RESULTS

1. CSO Performance against Year-2 Benchmarks

SUM II's Package of Support to CSOs for Year 2 included benchmarks for each quarter. The table below shows the benchmarks for the fourth quarter of Year 2 and CSOs' accomplishments.

Benchmark	Performance
Financial management: CSO leadership has completed annual budget based on at least 6 financial reports	All CSOs in DKI Jakarta and East Java submitted more than 6 monthly financial reports and completed annual budgets. Layak and Sadar Hati are suspended. Papua CSOs are submitting monthly financial statements. Annual budgets due in Feb 2013.
Strategic planning: CSO strategic plan is disseminated to staff, partners and stakeholders	All CSOs in DKI Jakarta and East Java have completed strategic plans, except Sadar Hati. Sadar Hati is suspended.
HR planning: CSO codes of conduct and service delivery protocols and procedures are disseminated to staff, partners and stakeholders Program planning and management: CSO 2nd annual program plan disseminated to staff, partners and stakeholders	Only some CSOs have completed codes of conduct (ethics). All have service delivery protocols and procedures distributed to staff. Many have developed SOP for recruitment and staffing. All have developed annual scopes of work and budgets for the coming year, except Layak and Sadar Hati, which were suspended.

Benchmark	Performance
Enabling environment activities: CSO strategic plan, with enabling environment goal(s) included, is disseminated to staff, partners and stakeholders	All CSO strategic plans include improving the enabling environment.
Advocacy: CSO strategic plan, with advocacy goal(s) included, is disseminated to staff, partners and stakeholders	All CSOs have developed action plans for advocacy and mobilization, except Layak and Sadar Hati, which are suspended.
M&E: Evaluation findings are fed into work plan for next grant year; All CSOs actively participate in District Annual Program Review; Annual survey	Based on performance, CSOs have been categorized as principal, developing or suspended. The TA to be provided, scopes of work and coverage are expanded for principal CSOs. All CSOs have participated in the annual surveys in their intervention sites.

2. Performance against Year-2 Targets

The target for the number of districts in which ERAs, OP/TC and health sector assessments have been undertaken has been achieved for year 2 and for the life of the project. The assessments will not continue. Twenty-one CSOs have approved grants, which is short of the target of 29. Four CSOs in Riau Islands and three in North Sumatra will be issued grants next quarter raising the number to 28.

District Offices and AIDS Commissions are supporting our CSOs. Nine CSOs leveraged funds from other sources in Year 2 (see section 3.4), which greatly exceeds expectations and target. SUM II's technical assistance in East Java has been particularly effective framing the comprehensive model, presenting compelling evidence of the resource needs, and supporting joint government and CSO planning and budgeting, which has led to government funding of our CSOs. The target for year 3 will be revised to reflect achievements and expectations for other provinces.

Although few details are available, DKI Jakarta AIDS Commission's budget increased in 2012. In East Java, the provincial AIDS Commission's budget increased by IDR 200 million, and Surabaya City's AIDS Commission's budget increased by IDR 17 million. In Malang District, HIV funding increased through SKPD at health, social welfare, culture and tourism and education offices, and at the health office in Malang City (amounts are not known).

The increase in the number of MARP individuals reached by CSOs during the fourth quarter of Year 2 reflects the contribution by Papua CSOs and initial contacts from previous quarters captured in the fourth quarter in Jakarta and East Java. The total achieved for Year 2 exceeds the target. HIV counseling and testing remains disappointing at intervention sites. Only 40% of the CSOs' target for year 2 was achieved. However, 64% of the annual achievement was in the fourth quarter demonstrating Papua's contribution. Other service targets reported here

achieved or surpassed their targets, which may suggest that availability of HCT at Puskesmas varies and is inadequate to meet demand at some sites.

STI services exceeded the Year-2 target because of the significant increase in services provided during the last quarter as well. Fifty-five percent of the STI services provided during the year occurred during the fourth quarter. It is much the same scenario with accessing HIV services at targeted intervention sites. There was a tremendous increase during the last quarter leading to almost achieving double the Year-2 target. The services include STI services, MMT and condoms dispensed.

The number of HIV-positive adults and children receiving a minimum of one clinical service exceeded the year-2 target by 27%. Fifty percent of the services delivered during the year were delivered in the last quarter.

See Appendix E for SUM II PMP indicator results.

3. CSO Annual Survey Results

SUM CSO partners in Jakarta and East Java conducted an annual survey in their intervention sites from March to June 2012. The aim of the survey was to determine MARPs' knowledge and HIV risk-related behavior after one year of program implementation. This survey addresses several questions – extent of coverage of program interventions to MARPs; MARPs' HIV comprehensive knowledge; and the practice of MARPs' HIV-related risk behavior, particularly sex and drug use behavior. The survey also enabled CSOs to gain experience conducting program evaluation and learning how evaluation results can lead to more appropriate and effective HIV intervention programs in subsequent years.

The survey's sampling method was two-stage, probability sampling proportional to size. Epi Info was used for data entry and data analysis. Total number of respondents was 2,610 (1,400 in Jakarta and 1,210 in East Java) – 68% male and 32% female. Of the respondents, 73% were CSO clients, 10% were not clients, and the remaining respondents were not asked or did not answer.

The survey shows that in January-March 2012 the total CSO contacts to clients varied – 24% of IDU respondents were contacted more than three times, whereas the percentage of FSWs, MSM, and TGs contacted two to three times were 34.3%, 12.7%, and 43.5% respectively.

At a minimum, members of MARPs are to know of the modes of HIV transmission and prevention, HCT and STI services, and, specific to IDUs, drug dependence treatment services. The percentage of respondents receiving this minimum information was 69% of TGs, 48% of IDUs, 46.8% of FSWs, and 39.5% of MSM. When respondents were asked five HIV-related questions, the percentage of respondents who could answer properly all five questions did not meet expectations. The highest percentage of respondents answering the five questions correctly was IDUs at 54.8%, followed by transgenders at 36%, MSM at 35.5%, and, the lowest,

FSWs at 26%. The result is not surprising since respondents who received the minimum required information were less than 70%.

With HIV risk-related behavior, sexual behavior in particular, transgender respondents were the highest proportion reporting condom use compared to other MARPs. In the last sexual intercourse, 90.5% of transgender respondents reported using a condom, followed by 71.2% of FSWs, 62.1% of MSM, and, the lowest, 37% of IDUs. However, on consistency of condom use in the last one-month (for FSWs in the last week and for MSM and transgenders as both inserters and recipients), the percentage drops for all MARPs with transgender at 44%, FSWs at 38.9%, IDUs at 23.1%, and MSM at 19.7%. With transgender respondents in particular, when they are the inserter the percentage of consistent condom use is less (46.5%) compared to when they are the recipient (81%). For MSM respondents, consistent condom use as the inserter is 26.8% and as recipient is 21.8%. Among IDUs 5.8% of respondents reported using a used needle and 62% reported sterilizing the needle beforehand for last injection.

Of CSO clients in January-March 2012, IDU respondents who were referred for sterile needles, methadone maintenance treatment, or drug rehabilitation service were 84.6%, 47.9%, and 40.2% respectively. In the same period, CSO clients referred to STI clinic were 80% of transgender clients, 75.5% of FSWs, and 67.8% of MSM, compared to CSO clients accessing STI service were 75.4% of transgender clients, 79.4% of FSWs, and 69.6% of MSM.

4. Recommendations for Year 3

1. *Expand coverage of HIV and STI services to MARPs and fill gaps by implementing in high-priority hotspots not currently covered to achieve PEPFAR targets*

SUM II will use grants to CSOs to improve their performance, aggressively expand coverage of MARPs, HIV and STI services, and to expand the role of *principal* CSOs in the HIV response. The strategy will include current grantees, other CSOs currently serving hotspots yet to be covered by SUM II, other community-based organizations coordinating with CSO grantees that can help increase coverage of MARPs, partnering with organizations that fund CSOs reaching MARPs for HIV and STI services, and supporting private clinics to provide services in hotspots.

2. *Continue to focus on community mobilization and advocacy as key outcomes of CSO organizational effectiveness.*

To *principal* CSOs SUM II will offer additional funding and technical assistance (TA) support to expand coverage and further strengthen programs. On-the-job training and coaching for *principal* CSOs will focus on ways to tap community and social activities of most-at-risk populations – to expand programs and coverage by recruiting volunteers and soliciting monetary and in-kind contributions; and on the way to build partnerships with other projects in the cities and districts that serve MARPs and PLHIV so that HIV services are mainstreamed in

these activities. *Principal* CSOs will partner with developing CSOs in advocacy to local government for increases in local funding for HIV services.

In our continuing roll-out of the *Resource Estimation Tool for Advocacy* (RETA*)*, SUM II will build the capacity of its own national and regional staff to conduct RETA exercises, train provincial and district AIDS Commissions and CSOs in RETA, and coach *principal* CSO partners in convening district stakeholders to conduct RETA exercises.

3. *Revise CSO surveys to focus on identifying barriers to implementation and performance, complement with qualitative assessments, and conduct semi-annually.*

Past CSO annual surveys have addressed knowledge, behaviors and utilization of services. Implementing the survey at the end of year 2 has required considerable TA because of the survey design. SUM II recommends that the surveys be conducted simplified and focused on CSO program implementation and performance, conducted and analyzed by the CSOs semi-annually. Furthermore, SUM II recommends that qualitative assessments be conducted by CSOs to further explain results from the surveys so that CSOs have a more in-depth understanding of the issues related to MARPs utilizing HIV and STI services.

4. *Assist principal CSOs to expand to new intervention sites and partner with CSOs currently operating effectively in the sites.*

SUM II has identified cost-effective means of expanding coverage by principal CSOs to new intervention sites where the CSOs have existing opportunities to provide services or where opportunities exist to partner with other CSOs currently operating in the intervention sites.

5. *Support partnerships between CSOs and private HIV and STI service providers to improve access and availability of services to MARPs in targeted intervention sites.*

SUM II will build partnerships between CSOs and private HIV and STI service providers currently providing the services and expand their service provision to our intervention sites or new ones to supplement services at Puskesmas. This strategy not only addresses MARPs underserved by Puskesmas but also barriers to Puskesmas access. In many cases MARP individuals prefer the convenience and privacy of private clinics providing free or subsidized HIV/STI services.

6. *Build the capacity of principal CSOs to deliver clinical HIV and STI services at intervention sites.*

Several SUM II CSOs have established clinics providing basic health care but do not provide HIV/STI services at these clinics or in our intervention sites. SUM II will assist selected CSOs to expand their service delivery to include registered HIV/STI services in our intervention sites.

Appendix A: FSW Baseline Survey Results

	Perumpung, East Jakarta	Moroseneng, Surabaya
FSW Characteristics	• 75.7% localized in street, park, warung, grave yard; others in entertainment establishments • Median age – 37 years • 53.4% lived with families	• 98% localized in brothel houses • Median age – 30 years • 91.4% lived with other FSWs at locations
Condom and Rinsing Vagina	• % FSWs with male condom – 57.8% • 28.7% purchased male condoms in past month • 52.2% received free condoms from NGOs; • Median number of male condoms that FSW had in last week – 2 condoms • 163 FSWs said condoms were freely distributed • 15% establishment managers provided male condoms • 38% of FSWs knew of female condoms, and 29% of these FSWs used a female condom • 79% of FSWs rinsed their vagina before having sex	• % FSWs with male condom – 83.5% • 67.5% purchased male condoms in past month • 38% received male condoms from health facilities, and 29.8% from Mami/managers • Median number of male condoms that FSW had in last week – 8 condoms • 56 FSWs said condoms freely distributed • 80.4% guesthouse/brothel managers provided male condoms • 79% of FSWs knew of female condoms, and 39% of these FSWs used a female condom • 97% of FSWs rinsed their vagina before having sex
Sexual Behavior	• 17 years (mean and median) – the first age of having sex • 37 months – median duration of working as FSW • 2 persons – median number in past week of guests/customers served with vaginal, anal and oral sex • 38% of FSW had sex with boyfriends in addition to customers • 70% FSWs in most recent sexual transaction offered customer a condom, with 55% willing to use a condom • 67% FSWs often/always offered condoms to customers • 48% of customers often/always used a condom • 82% of FSWs' boyfriends in past month never or rarely used a condom	• 17 years (mean and median) – the first age of having sex • 18 months – median duration working as FSW • 10 persons – median number in past week of guests/customers served with vaginal, anal and oral sex • 43% of FSW had sex with boyfriends in addition to customers • 81% FSWs in most recent sexual transaction offered customer a condom, with 57% willing to use a condom • 88% FSWs often/always offered condoms to customers • 61% of customers often/always used a condom • 61% of FSWs' boyfriends in past month never or rarely used a condom
Intervention Coverage	• 51% of FSWs had attended a meeting on HIV/STIs prevention • 44% of FSWs who said they never	• 69% of FSWs had attended a meeting on HIV/STIs prevention • 40% of FSWs who said they never discuss

	Perumpung, East Jakarta	Moroseneng, Surabaya
	discuss the risk of HIV and its prevention • 65% of FSWs who said they have never been referred to VCT clinic by NGOs or friends • 73% of FSWs have never been asked to demonstrate using a condom on an artificial penis in front of the outreach worker • 57% of FSWs who had never visited a STI clinic • 41% of FSWs did not receive free condoms in the last 3 months	the risk of HIV and its prevention • 71% of FSWs who said they have never been referred to VCT clinic by NGOs or friends • 74% of FSWs have never been asked to demonstrate using a condom on an artificial penis in front of the outreach worker • 29% of FSWs who had never visited a STI clinic • 27% of FSWs did not receive free condoms in the last 3 months
STD and HIV Tests	• 57.9% of FSWs who did their own treatment when experiencing symptoms of STI • 72.5% of FSWs with STD history visited STI clinics by their own willingness • 36.7% of FSWs tested their blood for HIV, with 57.6% saying they did so because they had higher risk of HIV infection	• 60.8% of FSWs who did their own treatment when experiencing symptoms of STI • 85.6% of FSWs with STD history visited STI clinics by their own willingness • 40.7% of FSWs tested their blood for HIV, with 40.7% saying they did so because they had higher risk of HIV infection
HIV/AIDS Knowledge	• 73.3% of FSWs had heard information about HIV ○ 21% radio ○ 39.2% TV ○ 29% newspapers ○ 47.8% posters, leaflets, booklets ○ 32.3% health officers ○ 15.1% field workers ○ 23.7% peers • 20% of FSWs said they can recognize someone who is HIV infected by their appearance • 64% of FSWs saying anal sex can reduce risk of HIV transmission • 41% of FSWs knew the place to get tested for HIV • 73.7% of FSWs know they are at risk for HIV • 79% of FSWs who said they had made efforts to avoid HIV • 23% FSWs said always used condoms	• 82.7% of FSWs had heard information about HIV ○ 21.8% radio ○ 46.9% TV ○ 33.3% newspapers ○ 56.6% posters, leaflets, booklets ○ 66.4% health workers ○ 15.1% field workers ○ 32.2% peers • 25% of FSWs said they can recognize someone who is HIV infected by their appearance • 38% of FSWs saying anal sex can reduce risk of HIV transmission • 26.7% of FSWs knew the place to get tested for HIV • 63.5% of FSWs know they are at risk of HIV • 92% of FSWs who said they had made efforts to avoid HIV • 22% FSWs said always used condoms

Appendix B: YEAR 1 and 2 CSO PARTNERS

YEARS 1 AND YEAR 2 CSO PARTNERS	
Jakarta	
1. Yayasan Kusuma Buana	*HIV/AIDS Prevention Program through Behavior Change Interventions among FSWs in West Jakarta*
2. Yayasan Inter Medika	*HIV/AIDS Prevention Program: Behavior Change Interventions among MSM in West, Central and South Jakarta*
3. Yayasan Srikandi Sejati	*HIV/AIDS Prevention Program through Behavior Change Interventions among transgenders in DKI Jakarta*
4. Yayasan Karya Bakti	*HIV/AIDS Prevention Program: Behavior Change Interventions among MSM in North and East Jakarta*
5. Yayasan Perkumpulan Bandungwang	*HIV/AIDS Prevention Program through Behavior Change Interventions among FSWs in East Jakarta*
6. Yayasan Atma Jaya – ARC	*HIV/AIDS Prevention Program through Behavior Change Interventions among IDUs in West and North Jakarta*
7. Yayasan Karisma	*HIV/AIDS Prevention Program through Behavior Change Interventions among IDUs in East Jakarta.*
Malang	
8. Lembaga Paramitra	*HIV/AIDS Prevention Program through Behavior Change Interventions among FSWs in Malang*
9. Yayasan Sadarhati	*HIV/AIDS Prevention Program through Behavior Change Interventions among IDUs in Malang*
10. Ikatan Gaya Arema	*HIV/AIDS Prevention Program: Behavior Change Interventions among MSM in Malang.*
Surabaya	
11. Yayasan Genta, Surabaya	*HIV/AIDS Prevention Program through Behavior Change Interventions among FSWs in Surabaya*
12. Yayasan Orbit, Surabaya	*HIV/AIDS Prevention Program through Behavior Change Interventions among IDUs in Surabaya*
13. Yayasan Gaya Nusantara	*HIV/AIDS Prevention Program: Behavior Change Interventions among MSM in Surabaya*
14. Persatuan Waria Kota	*HIV/AIDS Prevention Program through Behavior Change Interventions among Waria (transgenders) in Surabaya*
Papua	
15. Perkumpulan Keluarga Berencana Indonesia (PKBI) Daerah Papua	*HIV/AIDS Prevention Program through Behavior Change Interventions among MSM and TG in Jayapura City, and FSW in Tanjung Elmo, Jayapura District*
16. Yayasan Harapan Ibu (YHI)	*HIV/AIDS Prevention Program through Behavior Change Interventions among FSW in Jayapura City*
17. Yayasan Persekutuan Pelayanan Masirey (YPPM)	*HIV/AIDS Prevention Program: Behavior Change Interventions among high-risk men in Jayapura City and District*
18. Yayasan Caritas	*HIV/AIDS Prevention Program through Behavior Change Interventions among Indigenous adult women and men and high-risk men in Timika, the capital city of Mimika District*
19. Yayasan Usaha Kesejahteraan Ekonomi Masyarakat Desa	*HIV/AIDS Prevention Program through Behavior Change Interventions among I indigenous adult women in Wamena, the capital city of Jayawijaya District*

YEARS 1 AND YEAR 2 CSO PARTNERS	
Indonesia(YUKEMDI)	
20. Yayasan Tangan Peduli (TALI)	*HIV/AIDS Prevention Program through Behavior Change Interventions among adult indigenous men in Wamena, the capital city of Jayawijaya District.*
Riau Island	
21. Yayasan Bentan Serumpun (YBS)	*HIV/AIDS Prevention Program through Behavior Change Interventions among brothel-based FSWs in Batu-15 and Batu-24 brothels*
22. Yayasan Kompak (YK)	*HIV/AIDS Prevention Program through Behavior Change Interventions among indirect and direct FSWs in Bintan and Tanjungpinang, and PLWA*
23. Yayasan Embun Pelangi (YEP)	*HIV/AIDS Prevention Program: Behavior Change Interventions among IDUs, indirect and direct FSWs, and high-risk men of formal private sector in Batam city*
24. Yayasan Gaya Batam (YGB)	*HIV/AIDS Prevention Program through Behavior Change Interventions among MSM and TG in Batam city*
25. Yayasan Lintas Nusa (YLN)	*HIV/AIDS Prevention Program through Behavior Change Interventions among Brothel-based and indirect FSWs, and high-risk men of informal sector in Batam city*
North Sumatra	
26. Yayasan Galatea	*HIV/AIDS Prevention Program through Behavior Change Interventions among IDUs*
27. Perkumpulan Human Health Organization (H2O)	*HIV/AIDS Prevention Program through Behavior Change Interventions among indirect FSWs and HRM*
28. Lembaga Gerakan Sehat Masyarakat (GSM)	*HIV/AIDS Prevention Program: Behavior Change Interventions among MSM and TG*
29. NGO Forum	*CSO strengthening in advocacy, partnerships with government and other stakeholders; convening HIV response coordination meetings; and developing CSO advocacy strategies*

Appendix C: USAID SUM II YEAR-2 WORK PLAN PACKAGE OF SUPPORT for *Jakarta and East Java*

Year 2 Work Plan				
Core Areas of Support	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
SUM 2 Management				
Financial Management	SUM 2 Introduces the Package of Support on financial management to each CSO and the expected outcomes of this support; the implementation methods; the 12 month timeline of activities; and quarterly benchmarks 1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and Penabulu teambuilding and team planning completed • Finance staff are trained in first month by Penabulu based on the Implementation Manual and coached during the following 2 months • Introductory basic accounting system established and finance staff trained	TA provider, Penabulu, and CSO jointly address accounting system and staff capacity improvement needs, as per the CSO Improvement Plan (an accounting system that is fully operational and staff trained) 2nd Quarter Benchmarks • CSO accounting system is fully operational and the CSO has forwarded monthly financial reports as specified by the Manual	TA provider coaches financial staff and CSO leadership (on-site and virtual coaching) through a minimum of 7 cycles of monthly financial statements 3rd Quarter Benchmarks • CSO accounting system is upgraded and integrated for organization-wide use where applicable	TA provider ongoing coaching to financial staff and CSO leadership 4th Quarter Benchmarks • CSO leadership has completed annual budget based on at least 6 financial reports
Strategic Planning	SUM 2 Introduces the Package of Support on strategic planning to each CSO and the expected outcomes of this support; the implementation methods; the 12 month timeline of activities; and quarterly benchmarks	TA provider and each CSO jointly plan the consultative process for strategic plan development. The CSO conducts the consultative process (staff, MARPs, partners, stakeholders). 2nd Quarter Benchmarks	TA provider provides training sessions to the 15 CSOs on strategic planning definitions and format 3rd Quarter Benchmarks • CSO leaders and staff trained on strategic	TA provider coaches CSO staff and volunteers (in participatory planning sessions) to formulate program and service goals, objectives, milestones, and indicators of achievement; CSOs finalize strategic plans

Year 2 Work Plan				
Core Areas of Support	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
	1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provider teambuilding and team planning completed	• CSO leadership and staff complete consultation process with MARPs, partners and stakeholders	planning definitions and formats (as per the Manual)	TA provider coaches CSO leadership and staff on ways to operationalize the strategic plan with staff, volunteers, partners and stakeholders 4th Quarter Benchmarks • CSO strategic plan is disseminated to staff, partners and stakeholders
Human Resources Management	SUM 2 Introduces the Package of Support on human resources management to each CSO and the expected outcomes of this support; the implementation methods; the 12 month timeline of activities; and quarterly benchmarks 1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provide teambuilding and team planning completed	TA provider coaches CSO leadership on stewardship role and performance management approaches and skills, initiates process for development of policies and procedures 2nd Quarter Benchmarks • Policy and procedures development initiated	TA provider assists in review of CSO policies and procedures CSOs finalize IDUPPs 3rd Quarter Benchmarks • CSO staff and volunteers receive orientation session on CSO policies and procedures	TA provider conducts teambuilding sessions and team review meetings with leadership, staff and volunteers to: • Establish teamwork norms and ways to monitor them • Develop codes of conduct • Develop service delivery protocols and procedures 4th Quarter Benchmarks • CSO codes of conduct and service delivery protocols and procedures are disseminated to staff, partners and stakeholders
Program Planning and Management	SUM 2 Introduces the Package of Support on program planning and management to each CSO and the expected outcomes of this support; the implementation methods; the 12 month	TA provider and CSO jointly plan the stakeholder analysis to be conducted by the CSO program staff and volunteers CSO conducts stakeholder	TA provider coaches CSO program staff and volunteers in participatory activity and service work planning sessions (as per SUM *Module 4 – CSO Program Planning*)	TA provider ongoing coaching of CSO program managers and staff in program performance review processes 2nd Annual program plan

Year 2 Work Plan				
Core Areas of Support	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
	timeline of activities; and quarterly benchmarks 1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provider teambuilding and team planning completed	analysis 2nd Quarter Benchmarks • CSO stakeholder analysis completed	Annual program plan completed (with staffing, budget, timeline) TA provider coaches CSO program managers and staff in program performance review processes 3rd Quarter Benchmarks • CSOs complete one program perform review	completed 4th Quarter Benchmarks • CSO 2nd annual program plan disseminated to staff, partners and stakeholders
Joint SUM 1-SUM 2 Management				
Enabling Environment • *Key stakeholders (SUM 1)* • *CSOs (SUM 2)*	SUM 1 and 2 Introduce the Package of Support on program planning and management to each CSO and the expected outcomes of this support; the implementation methods; the 12 month timeline of activities; and quarterly benchmarks 1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provider teambuilding and team planning completed	TA provider engages CSO leaders and staff in a strategic thinking and consultation process to gauge the current situation in the district re: what are the legal and policy barriers; identify who the "key players;" and clarify the political processes involved in changing legal and policy barriers. 2nd Quarter Benchmarks • CSO situation analysis on enabling environment completed	TA provider coaches CSO (as part of the strategic planning and program planning process) on strategies to foster a collective effort by district leaders, members of key affected populations, law enforcers, and the public re: enabling environment 3rd Quarter Benchmarks • CSO strategies on enabling environment formulated	Ongoing TA provider coaching to enable CSO staff to develop enabling environment program goals, objectives, milestones, and indicators of achievement as part of the CSOs finalized strategic plan 4th Quarter Benchmarks CSO strategic plan, with enabling environment goal(s) included, is disseminated to staff, partners and stakeholders
Advocacy	Package of Support on program planning and management to each CSO and the expected outcomes of this support; the implementation methods; the 12 month timeline of activities; and quarterly benchmarks	TA provider assists CSO to develop an advocacy strategy that targets specific issues, people and institutions. 2nd Quarter Benchmarks • CSO advocacy targets	TA provider coaches CSO leaders and staff (as part of the strategic planning and program planning process) in the development of specific and measurable objectives of the advocacy campaign and	Ongoing TA provider coaching to enable CSO staff to develop advocacy campaign goals, objectives, milestones, and indicators of achievement as part of the CSOs finalized

Year 2 Work Plan				
Core Areas of Support	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
	1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provider teambuilding and team planning completed • CSOs develop resource estimations for advocacy using RETA	identified – issues, people and institutions	an action plan. 3rd Quarter Benchmarks • CSO advocacy campaign goals formulated	strategic plan 4th Quarter Benchmarks CSO strategic plan, with advocacy goal(s) included, is disseminated to staff, partners and stakeholders
Monitoring and Evaluation (CSO level)	SUM 1 and SUM 2 team conducts CSO training on M&E purpose, procedures, and SUM expectations 1st Quarter Benchmarks • SUM and CSOs have shared expectations for package of support roll-out and overall expected outcomes • SUM and TA provider teambuilding and team planning completed • Basic M&E training for CSOs completed • CSO monitoring procedures in place	SUM staff coaches CSO leadership and staff (on-site and virtual coaching) in doing routine assessment of on-going activities and progress (monitoring) 2nd Quarter Benchmarks • All CSOs complying with recording and reporting requirements • Routine feedback analysis system developed and functioning	SUM staff coaches CSO leadership and staff (on-site and virtual coaching) in doing routine assessment of on-going activities and progress (monitoring) 3rd Quarter Benchmarks • All CSOs complying with recording and reporting requirements • CSOs are able to identify well – performing program areas and those requiring improvement from monitoring data	SUM staff prepare jointly with CSO for end-of-SUM grant evaluation (after 12 months) of program achievements, as well as District Annual Program review 4th Quarter Benchmarks • Evaluation findings are fed into work plan for next grant year • All CSOs actively participate in District Annual Program Review • Annual survey

Appendix D: USAID SUM II YEAR-2 CSO WORKPLACE TRAINING, COACHING AND SYSTEMS DEVELOPMENT

DKI JAKARTA

Financial Management by Penabulu

No.	CSO	Phase	Result
1.	**LPA Karya Bakti**	Training/coaching to develop financial SOP and daily transaction reporting	Draft Policies and Procedures, and initial implementation of daily transaction reports
2.	**Yayasan Intermedika**	Training/coaching to develop financial SOP and daily transaction reporting	Draft Policies and Procedures, and initial implementation of daily transaction reports
3.	**Yayasan Bandungwangi**	FGD to finalize financial SOP and training/coaching for daily transaction reporting	Draft financial SOP and initial implementation of daily transaction reports
4.	**Yayasan Kusuma Buana**	FGD to finalize financial SOP and training/coaching for daily transaction reporting	Financial SOP and initial implementation of daily transaction reports
5.	**Yayasan Karisma**	Training/coaching to develop financial SOP and daily transaction reporting	Draft Policies and Procedures, and initial implementation of daily transaction reports
6.	**Yayasan Layak**	FGD to finalize financial SOP and training/coaching for daily transaction reporting	Draft financial SOP and initial implementation of daily transaction reports
7.	**Kios Atmajaya**	Training/coaching to develop financial SOP and daily transaction reporting	Draft Policies and Procedures, and initial implementation of daily transaction reports
8.	**Yayasan Srikandi Sejati**	Training/coaching to develop financial SOP and for daily transaction reporting	Draft Policies and Procedures, and initial implementation of daily transaction reports

Organizational Development by Circle Indonesia

No.	CSO	Phase	Result
1.	**LPA Karya Bakti**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization
2.	**Yayasan Intermedika**	Training/coaching to revise	Legal documentation, strategic

No.	CSO	Phase	Result
		constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	plan and action plan for advocacy and community mobilization
3.	**Yayasan Bandungwangi**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization
4.	**Yayasan Kusuma Buana**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization
5.	**Yayasan Karisma**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization
6.	**Yayasan Layak**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation and strategic plan
7.	**Kios Atmajaya**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization
8.	**Yayasan Srikandi Sejati**	Training/coaching to revise constitution, develop strategic plan, and training/coaching on advocacy and community mobilization	Legal documentation, strategic plan and action plan for advocacy and community mobilization

EAST JAVA

Financial Management by Penabulu

No	CSO	Phase	Result
1	**Gaya Nusantara**	Basic training/coaching on financial management, develop financial SOP, implement SANGO system for transaction recording, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports using SANGO
2	**Genta**	Basic training/coaching on financial management, develop financial SOP, implement SANGO system for transaction recording, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports using SANGO
3	**Paramitra**	Basic training/coaching on financial management, develop financial SOP and general ledger, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports using general ledger
4	**Orbit**	Basic training/coaching on financial management, develop financial SOP, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports
5	**Perwakos**	Basic training/coaching on financial management, develop financial SOP, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports
6	**Igama**	Basic training/coaching on financial management, develop financial SOP, and training in daily transaction reporting	Financial SOP, and initial implementation of daily transaction reports
7	**Sadarhati**	Financial SOP, and initial implementation of daily transaction reports	Financial SOP, and initial implementation of daily transaction reports

Organizational Development by Satunama

No	CSO	Phase	Result
1	**Gaya Nusantara**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation submitted to *Kemenhukham*, strategic plan, and action plan for advocacy and community mobilization
2	**Genta**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation in process by notary, strategic plan, and action plan for advocacy and community mobilization
3	**Paramitra**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation in process by notary, strategic plan, and action plan for advocacy and community mobilization
4	**Orbit**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation in process by notary, strategic plan, and action plan for advocacy and community mobilization
5	**Perwakos**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation in process by notary, strategic plan, and action plan for advocacy and community mobilization
6	**Igama**	Training/coaching to develop or revise constitution and apply for legal status, develop strategic plan, and advocacy and community mobilization	Legal status documentation in process by notary, strategic plan, and action plan for advocacy and community mobilization
7	**Sadarhati**	Training/coaching to develop or revise constitution and apply for legal status, and advocacy and community mobilization	Constitution documentation

PAPUA

Financial Management and Organizational Development by SUM II

No	CSO	Phase	Result
1	**Yukemdi**	TA from SUM II to develop work plan, procedures for staff recruitment and job descriptions, financial and program recordkeeping and reporting, mapping intervention sites, a code of ethics, advocacy to leverage funding and expanding HCT and STI referral to Puskesmas in Jayawijaya and TA to strengthen Dani Support Group	Detailed work plan, SOP for recruitment, map of intervention sites, code of ethics, staffing plan, established recordkeeping and reporting, award from AIDS Commission, agreement re condom availability among CHAI, DHO, DAC, Puskesmas, clinics, BKKBN and CSO
2	**Tali**	TA from SUM II to develop work plan, procedures for staff recruitment and job descriptions, financial and program recordkeeping and reporting, mapping intervention sites, a code of ethics, advocacy to leverage funding from a private company and support to Baliem Medical Center, expand HCT and STI referral to Puskesmas, training in basic knowledge of HIV/AIDS, STIs and condom use), and advocacy to improve condom access	Detailed work plan, SOP for recruitment, map of intervention sites, code of ethics, staffing plan, established recordkeeping and reporting, award from AIDS Commission, agreement re condom availability among CHAI, DHO, DAC, Puskesmas, clinics, BKKBN and CSO, document on HIV/STI basic knowledge, and established office space, equipment procured and staff recruited
3	**YCTP**	TA to develop work plan, recruitment procedures and job descriptions, map intervention sites, financial and program recordkeeping and reporting, BCI, basic HCT and MK services, strategy for community-based prevention, to synchronize our program with AIDS Commission, to collaborate with LPMAK, and advocacy to leverage funds from District AIDS Commission	Detailed work plan, map of intervention sites, SOP for financial and program recordkeeping and reporting, Documentation for BCI, VCT and MK, list of community groups and implementation plan; documented collaboration between DAC and YTCP, draft work plan between SUM II and LPMAK, list of community groups funded by DAC
4	**YHI**	TA to develop work plan, map intervention sites, financial and program recordkeeping and reporting, advocacy to strengthen HIV/STI referral system between CSO and service providers in Jayapura city/district, and to mobilize community groups	Detailed work plan, map of intervention sites, SOP for financial and program recordkeeping and reporting, list of community groups, agreement on strengthening HIV/STI referral system between CSO and service providers in Jayapura city/district
5	**YPPM**	TA to develop work plan, map intervention sites, financial and program recordkeeping and reporting, BCI, and advocacy to strengthen	Detailed work plan, map of intervention sites, SOP for financial and program recordkeeping and reporting, BCI documentation,

No	CSO	Phase	Result
		HIV/STI referral system between CSO and service providers in Jayapura city/district	agreement on strengthening HIV/STI referral system between CSO and service providers in Jayapura city/district
6	**PKBI**	TA to develop work plan, map intervention sites, financial and program recordkeeping and reporting, BCI, and advocacy to strengthen HIV/STI referral system between CSO and service providers in Jayapura city/district	Detailed work plan, map of intervention sites, SOP for financial and program recordkeeping, and agreement on strengthening HIV/STI referral system between CSO and service providers in Jayapura city/district

Appendix E: USAID SUM PROJECT *PMP INDICATOR RESULTS (SUM II)*

	Indicator	Target Y2	Achieved Y2/Q1	Achieved Y2/Q2	Achieved Y2/Q3	Achieved Y2/Q4	Achieved Y2 to Date	Achieved LOP	Target LOP	Notes Q4
1	Number of districts in which Expanded Readiness Assessments (ERA) and both OP/TC and Limited Health Sector Assessments have been undertaken	15	8	3	0	4	15	15	15	5 in Jakarta, 3 in East Java, 3 in Papua, 3 in Riau Islands, and 1 in North Sumatra. This indicator will be deleted in Year-3 PMP.
2	Number of CSOs with approved grants	29	15	0	6	0	21	21	29	8 in Jakarta, 7 in East Java, and 6 in Papua. Riau Islands and North Sumatra are finalizing scopes of work and budgets.
3	Number of CSOs that have received TA from the project and as a result have been able to leverage funding from other sources	2	0	0	4	6	10	10	12	The Year-3 and LOP targets will be adjusted based on past performance. IGAMA and Paramitra received funds from Welfare and Education District Offices. Genta received funds from District Welfare Office. Yukemdi and Tali received funds from District AIDS Commission. YHI received in-kind support (laundry machine) from Social Affairs District Office.
4	Number of districts with increased budget allocations for HIV	3	0	0	0	0	0	0	tbd	DKI Jakarta AIDS Commission budget for HIV increased but no details. Budgets for provincial and Surabaya city AIDS Commissions increased, and Malang city and district HIV funding increased through SKPD.
5	Percent budgetary increase in funding allocated by districts for HIV services	10	0	0	0	0	0	0	20	
6	Number of MARP individuals reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	38,300	10,441	5,807	2,200	25,494	43,942	43,942	98,882	In Q4 the number increased dramatically because Papua CSOs began implementing.
7	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results referred by CSOs	13,520	945	963	40	3,441	5,389	5,389	tbd	In Q4 the number increased dramatically because Papua CSOs began implementing.
8	Number of people accessing STI services at targeted intervention sites referred by CSOs	4,111	1,175	862	530	3,147	5,714	5,714	tbd	In Q4 the number increased dramatically because Papua CSOs began implementing.
9	Number of individuals accessing HIV services at targeted intervention sites	12,028	6,517	3,214	3,526	9,093	22,350	22,350	tbd	In Q4 the number increased dramatically because Papua CSOs began implementing.
10	Revised number of HIV-positive adults and children receiving a minimum of one clinical service	875	88	199	265	563	1,115	1,115	6,028	